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A HEALTHY PEACE?: REHABILITATION & DEVELOPMENT OF THE HEALTH SECTOR IN A 'POST'-CONFLICT SITUATION - THE CASE OF UGANDA

A report on a pilot study by

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Contents

Figures

Annexes

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The final responsiblity for the report rests, of course, with the authors.

Glossary

CBHCA	Community Based Health Care Association
CHAP	Community Health & AIDS Project (also known as the Second Health Project)
DA	District Administration
DMO	District Medical Officer
DP	Democratic Party
ESAF	Enhanced Structural Adjustment Facility
FHP	First Health Project
HPRC	Health Policy Review Commission
IMF	International Monetary Fund
KY	Kabaka Yekka Party
MFEP	Ministry of Finance & Economic Planning
MOH	Ministry of Health
MOLG	Ministry of Local Government
MSF	Medecins Sans Frontieres
NRA	National Resistance Army
NRC	National Resistance Council
NRM	National Resistance Movement
NURP	Northern Uganda Reconstruction Programme
PAPSCA	Programme to Alleviate Poverty and the Social Costs of Adjustment
PHC	Primary Health Care
RC	Resistance Committee/Council
RDP	Rehabilitation & Development Plan
UNLA	Uganda National Liberation Army
UPA	Uganda People's Army
UPC	Uganda People's Congress
UPDA	Uganda People's Democratic Army
USh	Uganda Shilling

EXECUTIVE SUMMARY

1.0 Introduction

This report presents the findings of a six month pilot study conducted by the Health Policy Unit at the London School of Hygiene & Tropical Medicine, in collaboration with Makerere University and HealthNet International. The project sought to investigate the policy dilemmas faced by national and international policy-makers responsible for 'post'-conflict [1] rehabilitation of the health sector in Uganda, and to evaluate the choices which were made.

Political violence poses a direct and indirect threat to the health of individuals, and populations, and to health systems. In many Third World countries conflict has exacerbated and compounded the structural weaknesses inherent in health systems in the pre-conflict era. Countries recovering from conflict therefore face a dual challenge with regard to health development in the 'post'-conflict period: to address both the general imbalances in the health system common to many Third World countries, and those particular social, political and health problems engendered and exacerbated by war.

The transition from war to relative peace is typically marked by changes of regime or system of governance. The achievement of peace and the process of recovery, rehabilitation and development therefore present opportunities for reappraisal of public policy in general and of health policy in particular. The rapid inflows of international aid also present an important financial opportunity for health systems development. Realising these opportunities for health development in 'post'-conflict situations will be contingent upon overcoming major structural obstacles in these unstable and resource poor environments. It will also demand more critical examination of the strengths and weaknesses of alternative approaches to rehabilitation policy design and implementation.

2.0 Context for Rehabilitation

2.1 Historical Context

Uganda has suffered nearly two decades of political violence under successive regimes. Extreme political instability and the associated economic devastation has left its population impoverished, and its health system in a state of collapse. In 1986, the National Resistance Movement (NRM) came to power. While new conflicts emerged in the northern regions of the

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[1] The achievement of peace is typically a relative process: the main body of conflict may be over, but violence may persist intermittently or continuously, nationally of within particular geographical areas. The term 'post'-conflict is used to indicate this.

country, the majority of districts embarked upon the difficult process of recovery. By 1992 relative peace had been secured in Uganda, and rehabilitation had begun in the north.

2.2 The Pre-conflict Health System

The health system inherited at independence in 1962 was based upon a network of hospitals and health centres, which were relatively well distributed throughout the country. These services concentrated on the provision of curative care. The expansion of health services during the 1960s reinforced the curative bias of provision, particularly at the secondary and tertiary levels. Primary health care had been largely neglected: it was only by the end of the decade that innovative programmes in support of PHC began to be developed. These were disrupted by successive conflicts.

2.3 Impact of War on Health & Health Systems

Conflict contributed to the significant reversal of health gains made during the 1960s. While Uganda had once been near the top of the league table in terms of health status and health services in Africa, by 1986 it was near the bottom.

The capacity of the health system to address this health crisis in the immediate 'post'–conflict period was critically constrained by two major factors. Firstly, even without conflict the Ugandan health system would have been neither sustainable economically nor appropriate to the health needs of the majority of the population. Conflict exacerbated these structural weaknesses. Two decades of fighting and neglect left the physical infrastructure in tatters. Financially, the public health sector was devastated: by 1986, the value of the public health budget was only 6.4% of its 1970 levels. The loss of key health personnel, destabilization of civil institutions, and the interruption of health debate within Uganda, and between it and the rest of Africa and the world, all contributed to the weakening of the health system.

3.0 Policy Response to the Rehabilitation Task

3.1 The Rehabilitation Strategy

A dual rehabilitation strategy was adopted in the immediate 'post'–conflict period: to restore the health system to its pre–1970s levels and to expand the availability of vertical primary health care services.

While this approach, endorsed by government and international agencies, responded to the *infrastructural* and material resource crisis, it did not address the underlying *structural* crisis inherited in the 'post'–conflict period. Significant development resources were made available

for the physical rehabilitation of the health infrastructure and for the introduction of vertical programmes such as the Expanded Programme for Immunisation (UNEPI) and the Essential Drugs Management Programme (EDMP). Both these interventions were based on the assumption that the most urgent task for health sector rehabilitation was to provide the "hardware" for health service delivery in the form of buildings and supplies. The task of health service rehabilitation was conceived as distinct from the longer term goals of health system development, and these early initiatives were seen as interim strategies upon which comprehensive and integrated health care could be built.

3.2 Policy Outcomes

These assumptions have not been borne out in practice. Instead, the considerable resources – capital and recurrent – made available for rehabilitation served to reinforce the structural weaknesses of the health system inherited from the colonial period and compounded by war. In particular, a major crisis of financing is now being experienced as the long–term recurrent costs associated with the earlier large–scale capital expenditure and the establishment of vertical programmes are incurred. The extent of government dependence on external aid is now being realised. Furthermore the financial crisis has led to extremely low levels of staff remuneration which threaten their capacity to deliver an effective service. There is a growing perception of the inadequacy of the existing health system to meet the priority needs of the majority of the population, particularly the rural poor.

The decisions regarding rehabilitation of the health sector in the immediate 'post'–conflict period have therefore had a profound impact on long–term health development in Uganda. Analysis of the process of policy development at this time suggests that a number of interrelated factors contributed to its failure.

4.0 Towards an Explanation of the Policy Response

The breakdown of policy institutions during the years of political chaos, and the difficulty of reestablishing them, meant that the rehabilitation of the health sector was not undertaken in a strategic manner. The absence of a coherent national health policy framework, meant that rehabilitation policy existed largely at the level of diverse and unintegrated programmes, supported by diverse international agencies. The failure of rehabilitation policies to meet their objective of providing a platform for long–term health and health systems development can be accounted for in terms of weaknesses in both the policy *process* and specific policy *content*.

4.1 Limitations of the Policy Process

Lack of Policy Fora

Political, professional and institutional interests which advocated the re-creation of the pre-conflict health system, tended to block the development of policy debates which might have promoted more fundamental reform and restructuring. The lack of policy fora within and between government and donors prevented an open appraisal of the nature of the rehabilitation and development task. There were no incentives for politicians or bureaucrats to acknowledge the nature and depth of the health crisis and to develop alternative policy scenarios. The political imperative to replace what had been lost reinforced the tendency to try to restore rather than redefine the health system. Communities themselves have had relatively little voice in determining priorities for health sector rehabilitation.

Role of Donors in Policy & Programme Development

Donors did not challenge this state of affairs by developing a policy dialogue with government. Rather, they acted within their own clearly defined areas of interest and expertise, without necessarily meeting the priority needs of the population. Donors contributed substantially to the costs of physical rehabilitation, but made little provision for the related recurrent costs which followed. International agencies constituted the major source of support for primary health care, while government expenditures were primarily directed towards secondary and tertiary care. This division of responsibility at an early stage helped to mask the crisis in government policy and in health financing, particularly of primary health care activities.

Pace of Policy-making & Planning

The pace at which rehabilitation planning took place constituted a major threat to appropriate policy development. The perception that the rehabilitation task was urgent was inspired both by humanitarian concern for the poor health status of the population, particularly in the most war-ravaged areas, and by the need to rapidly build political legitimacy. Yet, over-rapid interventions can result in ill-planned programmes which neither meet the priority health needs of war-affected populations, nor provide a platform for the development of sustainable health systems.

Making the Transition from Relief to Development

The transition from relief to development has been made with difficulty. During conflict-related emergencies, relief aid is typically channelled through the non-governmental sector. In the immediate 'post'-conflict period, bilateral and multilateral organisations have to rapidly establish relations with new and often unstable governments. Most international organisations have different operational mandates for relief and development activities which do not necessarily

recognise the particular needs of communities in the "grey" area of 'post'–conflict recovery. Weakened government bureaucracies and politicians with limited experience of the aid process are required to manage substantial and rapid inflows of aid.

4.2 Limitations of Policy Content

Choice of Focus

National and international agencies focused on the redevelopment of the health infrastructure in the immediate 'post'–conflict period. Health services are less important in determining health status than other factors such as nutrition and access to potable water and shelter. An additional focus for Ministry of Health activities in the immediate 'post'–conflict period, might be to support other ministries in rehabilitating health–related services and in improving environmental and living conditions.

Choices of Implementing Institution

The limited capacity and motivation of district level health workers and administrators to deliver health services has remained a major constraint to achieving functional rehabilitation. The low levels of staff remuneration were not addressed at an early stage of rehabilitation policy formulation. Similarly, the practice of informal charging for services and the low quality of health provision was not confronted in this initial period. This has meant that the trends for rapid and uncontrolled privatisation of provision, set in motion during the intra–conflict period, have persisted in the 'post'–conflict period, at least in part because of low staff morale in the public sector.

Health Needs of Conflict-affected Populations

Little attention has been paid to the particular health needs of communities recovering from prolonged periods of conflict. These are related to the direct effects of war on health, such as injury; and those related indirectly to conflict such as the spread of communicable diseases, including HIV/AIDS. Information regarding these special needs is scarce both because of the breakdown of the health information during conflict, and because conventional health surveys often do not accurately measure the incidence of physical disability and poor mental health. The psychological effects of conflict persist among many community members, particularly women, who bear the brunt of caring for and promoting the health of the community. War widows and orphans are likely to be particularly health deprived, as are the disabled. Little information is currently available regarding effective and affordable community–based interventions to address these particular health needs. The institutional and policy response to these needs has similarly been little examined. Poor health status was widely perceived by many communities as a major obstacle to wider social and economic recovery.

5.0 Learning Lessons?: Rehabilitation in the Northern Regions

Since early 1991 greater stability has been achieved in the northern regions, and discussion regarding strategies for rehabilitation of the health sector are gaining ground. These debates have been informed by the experience gained during the implementation of rehabilitation programmes in the southern and western regions, and by the development of national debates regarding decentralization. In particular, much less emphasis is being placed on physical rehabilitation and much more attention is being focused on rebuilding district capacity for planning and management, and on health financing issues. The strategy for rehabilitation in the northern regions is therefore to incorporate these areas into a national strategy for health sector reform, particularly of health financing and district management.

A potential limitation of such a strategy may be that it ignores the particular needs of a region which has historically remained relatively underdeveloped, and which has only relatively recently emerged from seven years of low-intensity war. The relative reluctance of donors to commit substantial resources to the rehabilitation of the north presents a major obstacle to development in the region, and is at odds with achieving their political objectives of improving security in Uganda. While donor caution is partially explained by their perception that on-going instability potentially threatens rehabilitation inputs, it is important to note that development of the economic and social sector in the north constitutes a pre-condition for promoting a sustainable peace in the area.

6.0 Issues & Implications

6.1 Setting Policy Agendas

The creation of transparent policy dialogue between communities, districts and central ministries, and between governments, donors and implementing agencies would improve the effectiveness of the rehabilitation process. Approaches which facilitate prioritisation of health needs and health interventions are urgently required. These might include both community-based, participatory methods and more economistic tools such as cost-effectiveness analysis.

6.2 Defining the Role of International Aid

Given the high degree of dependency on international aid and the likely weakness of state mechanisms for aid coordination, it will be particularly important that donors coordinate their activities and negotiate within the confines of a coherent national health policy if international aid is to be used to support sustainable development. Providing support - technical and financial - to develop such a framework is likely to be crucial.

6.4 **Facilitating the Relief/Development Transition**

It will be important for international organisations to strengthen their own institutional mechanisms to facilitate and coordinate the transition from relief to development activities. These might include developing special budgets for countries recovering from prolonged conflict, to provide medium-term support for rehabilitation, and encouraging relief and development staff to work together more closely to facilitate the transition to peace.

6.5 **Choosing Strategies**

It will be important that a multi-sectoral approach to health development guides the rehabilitation strategy. Such an emphasis would both confront the primary determinants of ill-health, and provide a more solid platform for the development of comprehensive primary health care. There will be a need to harness national and local political support, and donor resources, for these activities.

6.5 **Choosing Institutions**

It is important to assess the capacity of different institutions prior to implementation, and to explicitly acknowledge the possible conflict between policy objectives which strive to increase national and local institutional capacity and those which demand a rapid pace of implementation.

6.6 **Confronting the Information Gap**

The development of simplified disease surveillance techniques which provide rapid and accessible results for communities and health workers at the district and central levels will be vital. The potential of rapid and participatory techniques to provide information regarding health needs and resources requires further investigation.

6.7 **Confronting the Long-term Health Effects of Conflict**

There is a need to identify appropriate, community-based initiatives to support especially vulnerable groups and to identify their priority health needs. Meeting these needs will make a substantial contribution to securing wider social and economic recovery.

6.8 **Planning in Unstable Situations**

Developing a policy framework and planning mechanisms which are flexible and responsive to the different needs of different regions will be important. Similarly it will be necessary to identify appropriate strategies for rehabilitation within "pockets of peace" even while relative insecurity persists.

7.0 Conclusions

The structural weaknesses in the health system in Uganda in 1986 were not unique to that country. The long-term effects of conflict on the health status of the population and on the national health system meant, however, that the country faced additional problems, and lacked many of the resources to overcome them.

In 1986 fundamental decisions regarding the nature and direction of the health system were made. The strategies embraced by national and international health agencies tended to be expansionary, yet the financing base had contracted massively. The nature of the health crisis in 1986 was not fully acknowledged or understood. This misconception of the rehabilitation task has meant that future attempts to reform the health sector will have to overcome a triple burden: the inheritance of an inappropriate health system from colonial times; the long-term effects of war and the effects of the rehabilitation programme. The history of rehabilitation policy in the health sector in Uganda might therefore be described as a missed opportunity for health development.

Some seven years later the implications of these choices are becoming clear and there is a widespread acceptance of the need for restructuring and reform of the health system.

Learning the lessons of the Ugandan experience of health sector rehabilitation since 1986 will require much greater understanding of the process of policy development in these unstable situations, and assessment of the relative strength of alternative rehabilitation strategies. It will also require much greater sensitivity and flexibility on behalf of the international community, if aid is to contribute to developmental rehabilitation, rather than distorting the development of the health system. Achieving sustainable health development in 'post'-conflict situations will demand setting modest objectives which are affordable and appropriate within the country context and conform to the expressed priorities of communities. Meeting these objectives will depend upon developing transparent mechanisms for community participation and genuine dialogue between donors and national policy-elites for policy formation and implementation.

1.0 INTRODUCTION

1.1 Background to the Study

Political violence is a major feature of the policy environment throughout the developing world. It also has profound implications for public health. Although the initial optimism for peace generated by the end of the Cold War appears to be misplaced, in recent years an increasing number of countries have been making the slow and difficult transition from war to relative peace and stability. Cambodia, El Salvador, Ethiopia, Eritrea, Mozambique, Namibia, Somaliland and Uganda are but some of the countries currently embarking upon this difficult process.

The development of this research has been guided by two basic assumptions. Firstly, that conflict generates profound structural changes in political, social and economic institutions which are fundamental to health and to the organization of health systems, and that these changes persist long after relative peace has been secured. Secondly, that the achievement of relative peace marks an opportunity for health development, but that considerable constraints – political, economic, national and international, may threaten its realisation.

This report describes the main findings from a pilot study conducted over a six month period (January–July 1993), which focused on Uganda. This initial study had three primary objectives:

i. To review the effects of conflict on health and health services, and to analyze the impact of conflict on health policy, planning and implementational capacity in Uganda.

ii. To identify the key factors determining health policy choice and implementation in the 'post'–conflict era in Uganda, with particular reference to primary health care policy.

iii. To provide a basis for the further development of a research proposal for a larger, comparative study of health policy in 'post'–conflict situations. In particular, the pilot project was seen as an opportunity to refine methods, elucidate further questions and approaches to the study of policy issues in unstable economic and political environments, and to shed light on the feasibility and relevance of the proposed expanded study, for which funding is currently being sought.

This project forms part of a wider programme of work being conducted at the London School of Hygiene and Tropical Medicine by the Health Economics and Financing Programme concerning restructuring and reform of the health sector in developing countries, and research concerning policy processes being developed by the International Health Policy Programme.

The fieldwork costs of the pilot study were supported by HealthNet International, a sister organisation of Medecins Sans Frontieres (Holland). The Health Policy Unit and the Health Economics & Financing Programme at the London School of Hygiene & Tropical Medicine contributed all other costs.

1.2 Methodology

1.2.1 *Theoretical Framework*

The theoretical framework for the study derives from a body of literature concerned with the determinants of policy choice and implementation in developing countries. The choice of this framework has been guided by the belief that policy formation and implementation is the product of a complex political, economic and social environment. By understanding the behaviour and motivations of key actors and institutions within this environment, it is possible to find "spaces" to facilitate and influence policy change, and to identify those factors which act as bottlenecks and obstacles to the design and implementation of appropriate policy.

The particular framework employed is that developed by Grindle & Thomas (1991), which provides a basis for analysis of factors determining policy choice and influencing implementation. These include: technical analysis, political stability and support, bureaucratic motivation and international leverage. This matrix, together with that identified by Roemer (1991) to analyze the functioning of health systems, has been used to guide and order the collection of information. However, the research has identified some limitations of the respective models, and these are reported in the analysis which follows.

Defining the boundaries of such a research project presents formidable methodological and conceptual challenges. An important aim of the pilot study was to try to identify the key issues and concerns of researchers and practitioners working in 'post'-conflict situations which would merit further investigation in the proposed expanded study. In order to do this the canvas of this preliminary study was necessarily broad and attempted to avoid imposing too rigid a research agenda - instead, the study sought to conduct a review of the health sector which was sensitive to the particular effects of political and economic stress on health systems, and which enabled documentation of the 'post'-conflict rehabilitation process. The potential weakness of such an approach lies in its breadth which necessarily limits the depth and detail of investigation on any single issue. However, it is hoped that this open approach has allowed key issues to emerge through the research process, and enabled those responsible for health development in these situations to voice their priorities and concerns. These issues will be taken up further in the expanded research.

A second important "boundary" problem lies in identifying the time-frame for the study, which is in turn related to defining what constitutes "post-conflict situations". The main period under consideration for this study is that between 1986 and the present, however, the importance of events and patterns of health development prior to this point is recognised explicitly and implicitly throughout the study. While many countries are described as entering a 'post'-conflict period, it is exceptional for nationwide peace to be achieved, and pockets (often quite large ones) of instability are likely to be encountered either intermittently over time and/or in defined areas. Uganda is no exception to this: 1986 did not mark the end of conflict; rather, in some areas it marked the beginning of a new era of political strife.

There is a case for arguing that whether a country has entered into the 'post'-conflict period is in the eye of the beholder. In 1986 there was a perception among large sections of the Ugandan population, bureaucracy, polity and among international donors that the war was substantially over: this was manifest by communities moving back to their homes, politicians drafting long-term policy objectives and bureaucrats formulating rehabilitation plans. Among the international community too there was consensus that the NRM government was likely to remain in power, and donors contributed significantly to 'post'-conflict rehabilitation. While there is a potential cost in employing such a relative approach, particularly insofar that it risks underestimating the human, political and economic costs of on-going violence in those areas which remain at war, it captures the reality of conflict in many developing countries. The relativism implied in this definition can also be used to advocate an incremental and flexible approach to rehabilitation, which recognises that different areas are likely to be affected differentially over time and that interventions in each will require a detailed understanding of the security, economic and social situations if rehabilitation is to be appropriate to the needs of specific communities. It also acknowledges that rehabilitation of the social infrastructure may constitute part of the process of conflict resolution.

It is likely that the nature of conflict will determine the particular problems experienced in the 'post'-conflict period and how these problems are dealt with. The political violence experienced in Uganda could be described as multi-causal -the product of the colonial inheritance, religious and ethnic tensions, militarism and despotism. The researchers are therefore currently exploring different typologies used to describe political violence as a prelude to developing a schema for understanding the features of 'post'-conflict situations resulting from different forms of political violence and conflict.

This report is primarily concerned with public policy operating within formal bureaucracies at the central and district levels. At the same time, however, it is recognised that the actual role of government in health service delivery in 'post'-conflict situations may be less significant than that of self-management

and use of the private sector, including the for-profit sector and NGOs. There are two key reasons for emphasising the importance of public policy development in these situations. Firstly, the reestablishment of public social services is an integral part of the broader process of building the legitimacy of the state - an important pre-condition to the development of a sustainable peace. Secondly, health is seen as a public good and human right, which also carries important public benefits particularly insofar that it enables increased participation in social and economic life. While the state need not be the sole or even major provider of health services, it is important that it does have the capacity to develop key policy objectives, allocate resources to promote equity and regulate the activities of different providers. Important questions remain regarding how these functions can be effectively met in situations of extreme political and economic stress. By examining the interaction between the public and private sectors, and national and international actors in health systems development this report aims to understand how governmental capacity to meet its obligations can be enhanced while maximising the opportunities provided by mobilising the resources of other alternative institutions.

1.2.2 *Method*

The project was conducted over a six month period, including two months fieldwork in Uganda. Prior to undertaking the fieldwork stage a workshop was held at the Health Policy Unit to develop the methodology and finalise the research design. (Annex 1 presents the conceptual framework used by the study and Annex 2 presents the list of question areas.)

The research focus was on understanding national level policy processes; as a result the majority of the fieldwork was conducted in Kampala and Entebbe.

In order to gain a view from the district of the effects of conflict and of national policy development, a total of approximately 3 weeks was spent in Soroti and Luwero districts. This offered the opportunity to study one area where rehabilitation has taken place uninterrupted since 1986 (Luwero), while Soroti provided the opportunity to examine the needs and capacity of areas in the immediate 'post'-conflict period. Luwero district suffered from the effects of violence which has plagued the country since the early 1970s, but particularly in the early 1980s under Milton Obote. Since 1986, however, the district has been generally peaceful. Soroti district in the north- east of the country entered its most intense period of conflict following the National Resistance Movement's (NRM) accession to power in 1986. The violence which ensued was the result both of a rebel insurgency and the government's ripostes, and of the raiding by neighbouring Karamojong throughout the Teso region[2]. While considerable progress has been made in terms of conflict resolution between government and rebel forces throughout Teso, the threat of instability persists because of intermittent raiding from Karamoja.

A second factor which determined the choice of area was the involvement of MSF-Holland/HealthNet, co-funders of the study, in these two areas. MSF-Holland was operational in these districts during the conflict-generated emergencies and was active in rehabilitating the health infrastructure. MSF-Holland handed over its health work in Luwero to another NGO, AMREF, in 1989, while in Soroti, HealthNet International is developing a programme concerned with long term health development.

Data collection combined a review of documentation in the UK and Uganda with interviews with selected informants at central and district levels. A snowball sample was generated and semi-structured interviews, about 30 in number, were held with national level decision-makers within ministries of Health, Local Government and Finance, multilateral, bilateral and non-governmental organizations, newspaper editors, and academics. In addition follow up discussions with a number of informants were held. At the district level, semi-structured interviews were conducted with the district health team, district administrators and treasurers, and a series of focused group discussions were held with health workers, women and men in peri-urban and rural areas. In Soroti, MSF staff assisted in

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[2] "Teso" is the name of the region in the north east of Uganda which is inhabited primarily by the Iteso ethnic group. Following boundary changes the region was divided into two districts - Soroti and Kumi.

the selection of different interview sites. Criteria for selection included: main type of health service provider – public/mission; distance from Soroti town; (non–)intervention of NGO in rehabilitation of health infrastructure; more/less intensively affected by conflict. Members of the District Administration facilitated these visits by identifying potential informants at each village, and notifying health workers and local leaders of our itinerary. In Luwero, a less representative sample of the district was possible due to logistical and time constraints. The Luwero interviews were conducted in Luwero town, and the sub–counties of Bututumula and Semuto, both of which are relatively prosperous and accessible areas of the district.

All the interviews in Kampala, Entebbe and the district administration level were conducted in English. In Soroti, interviews were conducted in either Iteso or English; translation was provided where necessary by participants in the meetings and by the MSF driver who accompanied us. In Luwero, interviews were conducted in Luganda, and translated by one of the researchers (HB).

All interviews were recorded either on tape or in long–hand, and later transcribed by the researchers (JM and HB) and stored on computer disk.

In the final week of the fieldwork a seminar was held at the Child Health Development Centre in Kampala which brought together academics and representatives of health agencies to discuss the preliminary research findings. The comments and ideas of the participants greatly contributed to the research process. A draft report was circulated to a number of people with particular knowledge of the issues described with the report, this helped identify inaccuracies, ambiguities and clarify matters of interpretation.

1.2.3 *Methodological issues arising out of the research*

Several important issues regarding research design have arisen during the course of this work. For example, there is a need to establish strong links with collaborating agencies prior to the fieldwork stage in order to facilitate access to informants and information, and to identify potential "tracer" agencies for more detailed analysis. Other issues for discussion include the potentials and limitations of adopting more participatory methods at the district and village levels. These are not examined in any great detail in this report as they fall beyond its scope. However, three key issues are of relevance to this report: generalisability; access to key informants and validation.

There are two levels of generalisability which merit comment. The first relates to the pilot study and specifically whether the experiences of the two districts examined are generalisable to Uganda as a whole. Clearly each district has its own history and circumstances; we believe, however, that Luwero which experienced the brunt of the conflict in the late 1970s and early 1980s, and Soroti which was most affected in the late 1980s offer opportunities for understanding what was happening in Uganda generally during the two rehabilitation phases. The second issue of generalisability relates to whether the Uganda case study may offer lessons for other countries. This remains to be tested in the subsequent period of research.

In addition, the difficulties of differentiating the peculiar and particular impact of conflict from the multiple factors influencing health development are noted and methodologies to do so require refinement. Access to key informants was generally good: inevitably, however, certain key figures were inaccessible, and it was not always possible to identify those who had been involved in strategic decisions in the period under study both within national and international health agencies. The fact that Uganda is currently engaged in a major process of health sector reform meant that most informants were open to a process of research which sought to evaluate the strengths and weaknesses of former policies.A significant period of time has elapsed since initial rehabilitation plans were formulated in 1986–7, people's recollection of events is likely to be coloured by their more recent experience. Finally, the process of validation of the research findings has relied upon adopting methods of triangulation – comparing interview material, written source documentation and other descriptions of the events and processes at the time. However, these methods breakdown to some extent in any attempt to look

"behind" formal decision-making processes: in other words in many cases it has been necessary to rely solely upon a comparative analysis of interview material to identify the determinants of policy choice. Where there was a substantive lack of consensus between informants regarding matters of interpretation this is indicated in the text.

1.3 Structure of the Report

The report which follows is structured in four parts. Section 2 describes the political and economic context within which recovery has taken place. Section 3 concerns the effects of conflict on health systems, the policy response to the challenge of rehabilitation and the key actors involved in the process of policy design and implementation in the period 1986-1990. It also analyses the determinants of policy choice and successful implementation. Section 4 describes the changing context of health policy in Uganda since 1990 and analyses the potential influence of these developments on rehabilitation strategies in the north. The final section identifies the key issues arising from the research and assesses the implications of the findings for future policy development both within Uganda and elsewhere, and includes discussion regarding both strategic issues and matters of possible programme content. By identifying the factors which have influenced the choice of rehabilitation policy it aims to highlight policy spaces which might offer entry points to improve the equity, efficiency and effectiveness of recovery after prolonged periods of war. Finally, suggestions for further research around health policy development in 'post'-conflict societies are offered.

2.0 CONTEXT FOR RECOVERY

2.1 Political Context

2.1.2 *An Overview of Conflict*

The stage for conflict in Uganda was set in the colonial era which fostered a climate of ethnic division, differential and inequitable patterns of development and militarization of power (Brett, 1988). The colonial state comprised three ethnically and politically fragmented provinces and a fourth which consisted of an historically and politically coherent unit (Wrigley, 1988). It was this latter Province, Buganda, which formed the staging post for the creation of the British Protectorate of Uganda in the nineteenth century, and which acted as the political and commercial focus in the process of building a colonial state.

The Baganda were allowed to maintain their dominant position in the country, and from its peoples an educated and privileged national elite emerged (Low, 1988). In 1953 the *Kabaka* (king) of Buganda sought to retain its autonomy as a kingdom by entrenching special privileges for it in the federal constitution. The British authorities responded by deporting him, a move which angered those very groups who constituted a traditional base for nationalism. Clerks, teachers and farmers saw the removal of the *Kabaka* as a sign that they would be exposed to a post-independence order determined by white settlers, not one of majority rule. By the time the *Kabaka* returned to the country the constitutional settlement was well under way, blocking the possibility of Baganda independence; in 1955 Uganda was formally declared a multi-ethnic state (Wrigley, 1988).

The *Kabaka* and the ruling council the *Lukiko* responded by forming a party, the Kabaka Yekka (KY – Kabaka Only) Party, pressing for Baganda autonomy. This move seemed to consolidate anti-Baganda feeling elsewhere in the country. Milton Obote of the Uganda People's Congress (UPC) was at the forefront of the movement which challenged Baganda supremacy. In the pre-independence 1961 elections the Baganda were encouraged to boycott the ballot by *Kabaka* loyalists. This led to the surprise victory of the Democratic Party (DP), largely supported by a Catholic constituency, since Catholics within Buganda voted for the DP upsetting UPC victories elsewhere. Benedict Kiwanuka, leader of the DP, formed the first African Government in Uganda in 1962.

The UPC responded by forging an anti-DP alliance with the KY, forcing a second general election in 1962, which took Uganda into independence on the basis of a fragile coalition government, led by Milton Obote. The vulnerability of the coalition was highlighted during the so called "Lost Counties" crisis which split the UPC and KY. The breakdown of the coalition was to be the first of many which would dominate the political stage during the next two decades.

The path towards violence was set in 1966 when the constitution was suspended by Obote. The President ordered the army to attack the palace of the *Kabaka*. The forcible removal of the *Kabaka* was widely seen as the starting point for the disintegration of the civil order laid down prior to independence and for the process of militarization of power in the country. While President Obote retained power throughout these crises he did so only by creating a series of precarious coalitions, as these combined and collapsed, his dependence upon the army grew. Yet even this was to fail by 1971 when Idi Amin, a senior army officer effected a coup and seized power, with the support of Britain and Israel.

Box 1: Historical Overview of Uganda 1962–1992

1962	INDEPENDENCE – fragile coalition government, led by Milton Obote, of the Ugandan People's Congress (UPC)
1971	Idi Amin seizes power; political oppression of Langi, Acholi, West Nilers, Lugbara and Madi
1972	Expulsion of Asian population
1978	Amin forces attack Tanzania
1979	Moshi Conference – convened by President Nyerere in March. Yusuf Lule identified as leader of anti–Amin coalition
	Tanzanian and anti–Amin forces launch attacks in Uganda. Amin regime falls in April. Unstable transitional governments
1980	UPC win elections, but results widely contested. Under the Obote II regime up to 500,000 people killed.
	National Resistance Army (NRA) launches insurgency action against UPC, led by Yoweri Museveni
1985	Tensions within army increase, Chief of Staff Okello seizes power
	Nairobi agreement signed December – power shared equally between Tito Okello & NRA.
1986	January – NRA seizes Kampala, NRM government formed under the presidency of Yoweri Museveni
1986–1992	On–going insurgency in North: ex–UPC fighters; internal conflict in Karamoja; Alice Spirit Movement.
	Now largely under control, banditry persists.

Amin's army, like the government, was characterised by ethnic division which had hardened under the factionalized political system of the late 1960s and early 1970s. The new President sought to quash these threats to his power by mounting vicious campaigns against the Langi and Acholi citizens and soldiers who had been the mainstay of his predecessor's support. Once again, to compensate for the alienation of a substantial proportion of the population, Amin sought to build bridges of coalition with other key groups, but these collapsed under the political strain. By 1972, his failure to establish a solid political base led him to conduct the so called "economic war" which led to the expulsion of Uganda's Asian community of 80,000 people. This attempt to gain popular support for the supposed "Africanisation" of Ugandan commercial and professional life failed to yield sustained political support, and catalysed a process of economic collapse and chaos which was to haunt the regime until its overthrow in 1979.

The economic war culminated in the development of a parallel economy which was to depend upon strong links between the public and private sectors. The complex articulation between the two sectors is well captured in Green (1981).

Throughout the 1970s the predatory rule of Amin had been a source of concern to the Tanzanian government, which had supported debate among Ugandan exiles living in that country regarding possible directions for their home country. As his power base weakened, Amin launched a diversionary attack on Tanzania in 1978, prompting a tough riposte from that country's President, Julius Nyerere. By April 1979 the Amin government had collapsed.

The end of Amin's regime brought a succession of transitional governments into power led first by Yusuf Lule, and subsequently by Binaisa and Paulo Mawanga. Each of these leaders served to further alienate segments of Uganda's rich variety of ethnic groups and create further divisions within the ever powerful army.

1980 brought Milton Obote back into the Presidential seat in an election which was widely considered to be fraudulent. Within months of his election, Obote faced insurgencies from a number of forces, primarily that of the National Resistance Army (NRA) led by Yoweri Museveni. The successes of this force prompted a new reign of terror by the Obote regime, which many have described as worse than that of Amin. Within the "Luwero Triangle" army troops forcibly resettled large populations in order to remove possible sources of civilian support for the NRA. These counter-insurgency strategies and the fighting itself led to an unknown number of deaths. In Luwero district alone, more than 200,000 skulls were found scattered, this figure does not include the numbers buried in mass graves (Luwero District, 1988).

Divisions within and between the army and government laid the way for another coup: led by Tito Okello, who seized power in July 1985. Peace negotiations between the new government and the NRM in Nairobi established a formal truce in December 1985. Within 6 weeks however, NRA forces took power, installing Museveni as Uganda's eighth president.

The NRM government faced armed opposition in the northern and north- eastern provinces almost immediately on taking power. By August 1986 two insurgency groups had emerged in the northern districts of Gulu and Kitgum - the Uganda People's Democratic Army (UPDA) and the messianic sect of Alice Lakwena. Lakwena's forces were routed in Jinja in late 1987, and a peace agreement made with a substantial part of the UPDA. However, other smaller messianic sects formed and rebel activity persisted. In 1991 a major military operation was mounted against northern rebels, which entailed substantial forcible relocation of civilians, adding to the number of people killed and displaced from their homes. By 1992 violence was primarily attributable to banditry rather than to political opposition per se.

In the north eastern districts of Soroti and Kumi, armed opposition began in 1987 - many Iteso people had also been supporters of the Obote government. In 1986 one of the first actions of the NRA had been to disarm militia forces that had been formed by the Iteso to protect themselves from violent cattle raids from neighbouring Karamoja. The rebel movement the Uganda People's Army (UPA) took advantage of the resentment caused by this to mobilise support. Major counter-insurgency operations, similar to those in Gulu and Kitgum, were followed by a programme of pacification and conflict resolution led by a Presidential Commission. By 1992 security had largely been restored, however, the threat of Karamojong raids persists, undermining the process of recovery and rehabilitation.

2.1.2 *The NRM Political Programme*

Like many guerrilla movements which achieve power after prolonged insurgency, the NRM brought with it idealism, enthusiasm and hope. Several commentators have suggested however that it lacked a solid popular base of support and a corp of cadres able to perform the task of political mobilisation on its behalf (Burkey, 1991).

When the NRM took power it sought to implement what became known as the 10-point plan which had developed during the course of its insurgency struggle. The programme set out a range of objectives, including the achievement of democracy and security; the elimination of all forms of sectarianism; the defence of national boundaries from external aggression; the achievement of an integrated and self-sustaining economy; the rehabilitation of social services (particularly in war-ravaged areas); the ending of corruption; improving living conditions for those who had suffered disproportionately from previous government policies, including those displaced by conflict and development, those from deprived areas such as Karamoja, salaried people impoverished by inflation; the defence of human rights throughout Africa.

The NRM has sought to achieve these objectives by building consensus and unity across ethnic and party political lines. Democratic structures have been developed through a decentralized political system known as Resistance Committees and Councils (RC). This pyramidal system links village level committees (RC1) and parish level (RC2) [3] to the National Resistance Council through a series of sub-county (RC3), county (RC4) and district (RC5) committees.

Museveni characterises the RC system as "people's power", but, as Burkey (1991) suggests, there has been ambiguity in the way in which the role of the RCs has been conceptualised. As she puts it "..on the one hand they were to be the people's watchdog against corruption and abuses by government, on the other they were considered an integral part of the NRM. By blurring the distinction between these different functions of the RC system, the NRM sought to maintain the populist illusion that people, state and movement are one, united in the common purpose of development" (ibid).

Members of the National Resistance Council are drawn from a wide range of political and ethnic backgrounds: the NRM does not see itself as a political party, but rather as a political movement. Not all members of RCs at national, district and village level support the NRM, and some have held positions of power and influence at national level in previous administrations. Within the bureaucracy the NRM's agenda threatened those who had profited from the rapid and predatory expansion of the state under previous regimes.

Thus, Burkey (1991) suggests that the NRM faced two major constraints to implementing its agenda "on the one hand [there was] a bureaucracy resistant to radical change, on the other a passive population" cowed by years of political violence.

In 1988 a constitution commission was formed to investigate suitable mechanisms for the development of democracy in Uganda. A draft report was released in late 1992. This recommended that elections should be held for an interim administration to guide the development of the constitution, but warns of the possible risks of adopting western-style democratic institutions in the Uganda context. In mid-1993 there was a vigorous debate as to whether members of the National Resistance Council should automatically be appointed to the Constitutional Assembly. Donors are strongly pressing for more rapid moves towards political reform and are informally acknowledged to be threatening to make future aid conditional on the introduction of democratic principles, at least for the Constitutional Assembly.

2.2 Economic Legacy of War

2.2.1 *1962-1985: Decline & Collapse*

At independence expectations for sustained economic growth were high. The country's rich natural resource base was seen to provide the basis for rapid growth and expansion. Despite the structural constraints associated with the inheritance of an economy designed to meet the needs of the colonial centre rather than the majority of Ugandan nationals, the economy performed well (Brett, 1988).

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[3] RC2 committees are not generally operational.

Between 1963–1971 the GDP grew at an average rate of 4.5% per year. Since this expansion exceeded population growth, real per capita income increased from USh 694 in 1963 to Ush 752 in 1969 (Edmonds, 1988). The post-independence period was marked by an attempt to diversify the economy away from its reliance upon agricultural production, particularly coffee. However, industrial production increased by only 0.7%, while agriculture's share fell by 4% to 49.2%, as the export of other primary commodities such as copper increased.

The Amin regime reversed the economic and social gains of the first years of independence, leaving a legacy of structural obstacles to economic development which persisted long after its removal from power. The expulsion of the Asian community in 1972 left commercial and marketing structures critically weakened. In the same period many non-Asian Ugandans, often the most qualified, left the country, along with the majority of expatriate aid and commercial personnel.

Between 1971 and 1977 economic growth increased by only 0.4%; while population growth slowed, this was not significant enough to avoid a sharp drop in per capita income. Structural changes were also reversed, with a steady move away from the production of export crops towards subsistence agriculture – Edmonds (1988) suggests that by 1977 the subsistence sector accounted for 32.2% of production. The implications of the decline for public sector revenues was exacerbated by the growing illegalization of the economy (Green, 1981). This was associated with the development of the *magendo* or parallel economy, as the state lost formal control over the economic base, merchants and influential bureaucrats gained monopolies over the purchase and distribution of valuable primary commodities such as coffee and basic foodstuffs.

Amin sought to expand state control over production, marketing and distribution through the nationalization of many expatriate firms, leading to a massive expansion of the public sector from an estimated 50,000 employees in 1970 to 250,000 in the early 1980s (Commonwealth Secretariat, 1979; World Bank 1993). However, the degree of corruption and informalization of the "public" sector meant that the majority of its profits were in private hands (Green, 1981).

These trends were reflected in the substantial fall in formal export volumes, which Lateef (1990) estimates fell by 9.5% per annum between 1973 and 1980. They also had profound implications for effective management and accountability in the public sector as many civil servants were forced by low wages into extra-legal activities in order to survive.

In 1977 the economy collapsed. Between 1977 and 1980 GDP declined by 18.8%, which, expressed in per capita terms represented a fall of over 25% from 1970 levels. Figure 1 shows GDP and GDP per capita 1963–1990.

In order to appreciate the full magnitude of these figures, it is important to see them in the wider context of economic development of other African countries at this time. Lateef (1990) points out, for example, that while incomes per capita in low income countries in Sub-Saharan African (LISSA) countries fell by an average annual rate of 0.6% between 1973–1980, in Uganda the fall was 10 times greater (6.2%). Figure 2 compares GDP per capita 1965–1989 in Uganda with that of other Sub-Saharan African countries.

When Milton Obote took power in 1980, relations with western donors, which had largely collapsed during the Amin period were restored. Obote courted the international agencies in order to mobilise funds for rehabilitation (Economist Intelligence Unit, 1992). In line with a major report written by the Commonwealth Secretariat prepared in 1979 the government had identified the need for a large flow of imports to enable a return to effective food pricing structures and to rehabilitate the transport and production sector. Priority was given to economic recovery, while rehabilitation of the social sector was seen as dependent upon increasing overall economic performance.

The recovery programme was effective in encouraging real growth in the economy between 1980 and 1983 primarily because of the rechannelling of agricultural produce through the formal sector (Economist

Intelligence Unit, 1992). Yet the rehabilitation efforts were implemented within a somewhat paradoxical economic policy framework. The government had been forced to adopt a radical programme of stabilization and adjustment under the auspices of the IMF. While this achieved its desired effect in terms of reducing inflation, it has been suggested that the adoption of deflationary economic policy in the context of an economy which demanded rapid and substantial investment and expansion of the public sector threatened longer term development goals (Edmonds, 1988).

In 1984 growing tensions between the government and the IMF led donors to substantially reduce their assistance to the Obote government (Economist Intelligence Unit, 1992). This, combined with the intensification of the conflict with the NRA, meant that the brief improvements in the country's economic fortunes were reversed, and per capita incomes fell to new lows in 1985/6 (See Figure 1).

2.2.2 *1986-1992 Reversing the Economic Inheritance*

Economic recovery in the immediate 'post'-conflict period was threatened by structural weaknesses inherited from previous regimes, in particular low levels of public revenue due to low levels of cash crop production, high levels of subsistence agriculture, limited capacity to collect taxes and the illegalization of the economy. In addition, high levels of defence expenditure continued throughout the late 1980s and early 1990s.

Recovery of public sector finances was limited by the extremely low and narrow tax base inherited from the previous regimes. By 1990 public revenues accounted for only 6% of GDP, and improvements had been slower than anticipated (Twaddle, 1988; Lateef, 1990; Uganda, 1992).

The pace of recovery of public sector finances was further slowed not only by the relatively sluggish pace of donor response to requests for assistance, but more significantly by the insurgency in the north of the country which led to humanitarian emergencies and high defence expenditures. Official figures suggest that in 1988/89 defence expenditure rose to 31.5% of the national budget (Uganda, 1989). Accurate figures on military expenditure are notoriously difficult to obtain: several informants concurred however, that even this high figure is likely to be an underestimate, and that actual figures in 1990 might have risen considerably higher. Government borrowing figures provide some indication of the extent of stress in public sector finances. In 1986/7 the budget ended with a deficit equivalent to 95% of its total revenue (Economist Intelligence Unit, 1992), a figure which is not rapidly improving.

In an attempt to address these structural weaknesses, and to attract increased donor support, the NRM signed an agreement with the IMF in May 1987 which committed the country to a programme of stabilization. This was swiftly followed by the negotiation of a Structural Adjustment Facility (SAF) with the World Bank. The launching of the first Rehabilitation and Development Plan (RDP) in 1987 was preceded by a package of measures including currency reform, tight budgeting and cost-cutting which gained support from both Bretton Woods institutions (Economist Intelligence Unit, 1992). The SAF was replaced in April 1988 by an Enhanced Structural Adjustment Facility (ESAF) following the government's decision to deepened and hasten the pace of reforms. Since 1988 Uganda has been eligible to draw resources from the World Bank-sponsored concessional aid flows to debt-distressed low income countries (Lateef, 1990)

The RDP called for funding (largely from external aid) of more than US$1 billion over four years. Donor response to this appeal was slow as they tried to understand the nature of the NRM's political agenda, and were cautious of supporting a regime initially perceived as inclined towards socialism. By 1987/88 aid receipts had improved dramatically, but considerable funding gaps remained (Uganda, 1989).

Government documents report that considerable funding problems were experienced and that the lack of foreign exchange was a critical constraint on rehabilitation activities. It was perhaps in an attempt to improve donor response to the rehabilitation effort that a revised version of the rehabilitation plan was prepared for the period 1988/89-1990/1 (Uganda, 1989). This second document comprises two volumes - an outline of macroeconomic framework and a list of proposed activities, project by project.

While the first RDP had allocated 17% of funds towards the social sector this had been increased to some 25.2% in the second plan.

Aid has constituted a significant proportion of GDP since 1986 – by the end of the 1980s official aid accounted for almost 10% of national GDP (de Coninck, 1992). The per capita figures reflect more accurately the relatively low levels of aid Uganda receives because of the absolutely low levels of public revenue. Per capita aid receipts remain low relative to other countries in the region (World Bank, 1993). The reasons for this remain unclear, but are likely to include the relatively low absorptive capacity of the government, combined with other international, strategic concerns.

While growth rates averaged 6–7% per annum between 1987–1989 (Uganda, 1989), this fell sharply to 4% in 1990. A recent report suggests that official projections for growth from 1991–2 were estimated at a steady 3.5–5% (Save the Children Fund, 1993). Several commentators have noted that the 1987 high growth rates are probably exceptional, reflecting the inflow of aid funds for reconstruction purposes (Uganda, 1989; de Coninck, 1992).

Growth since 1986 has not been shared equally: de Coninck (1992) notes rising inequality of income distribution. Some efforts have been made under the World Bank Programme to Alleviate Poverty and the Social Costs of Adjustment (PAPSCA), which targets vulnerable groups including widows, orphans, the disabled and retrenched civil servants (de Coninck, 1992). The total budget of the scheme is US$106 million over 3 years (1990–3). Given the dramatic increases in poverty during the 1970s and 1980s reflected in the falls in per capita income shown in Table 1, it is unlikely that this programme will have a significant impact on poverty reduction.

2.3 Conclusion

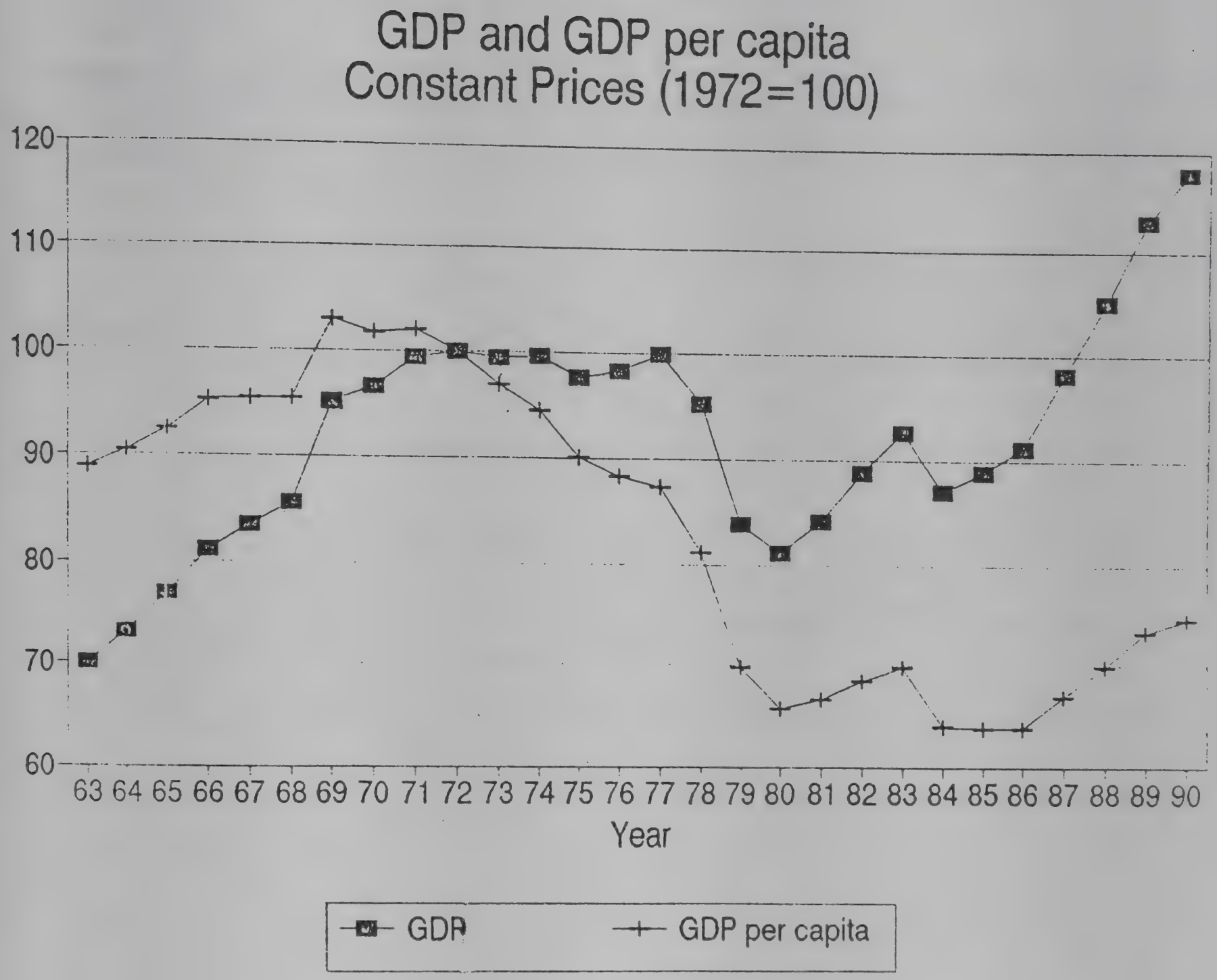
The post–independence period in Uganda has been characterised by division, insecurity and the militarization of power. Successive conflicts in Uganda have been a response to the task of nation building across complex ethnic and religious lines. Every region of the country has been affected by the direct and indirect consequence of conflict at different periods. The NRM has mapped out an agenda of political reform and democratization. Realising this agenda will depend upon strengthening national political institutions, particularly at the grassroots levels. Many important political figures at the national and local level have served in previous regimes, and the NRM constantly has to balance potentially conflicting objectives of maintaining national unity with its commitment to investigate past human rights abuses and corruption. There is concern among many Ugandans and among some members of the international community that the pace and style of democratization should be carefully controlled and planned given the country's history.

As conflicts have developed the economic stakes of different groups in sustaining or resolving conflict have changed. No analysis of the long term political consequences of the *magendo* or parallel economy have been found which clearly identify the different stake–holders in the maintenance of this economy. However, several commentators (for example, Burkey, 1991) have suggested that the behaviour of the bureaucracy and the capacity of the government to mobilise political support has been limited by the persistence of a political economy which threatens the equitable and effective allocation of scarce resources and the process of democratization.

Political instability has been accompanied by massive disruption of economic life. The strength of this correlation is illustrated by the relative depth of the economic crisis in Uganda compared with non–conflict low income countries in Africa. While economic growth has been impressive since 1986, GDP per capita remains below that achieved prior to 1970, in addition there are concerns that the rate of growth is neither sustainable nor being shared equitably (de Coninck, 1992).

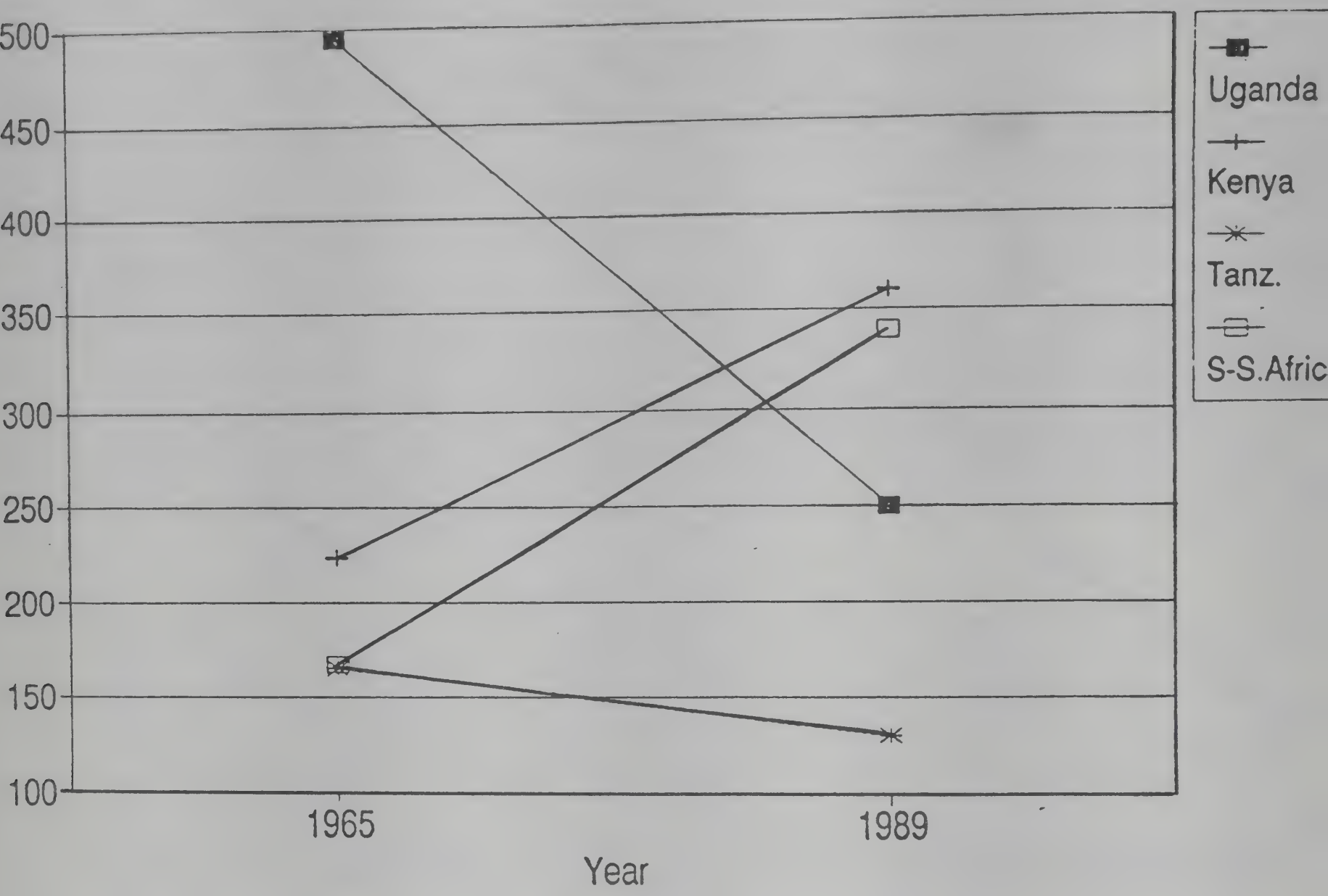
These features of the Ugandan political economy have significant implications in the context of this study. The threat of ongoing instability in the northern regions of the country undoubtedly limited the political attention that could be given to the rehabilitation task, particularly in the social sector. The lack

Figure 1: GDP & GDP/capita 1962–1989



Source: Save the Children Fund, 1993

Figure 2: GDP per capita 1965 and 1989 Uganda, Kenya, Tanzania, Sub-Saharan Africa



Source: Save the Children Fund, 1993

of a tradition of political participation and the effects of years of violence diminished the capacity of communities to influence social policy development.

Within both the political and the bureaucratic domain there was a resistance to radical change which potentially threatened interests, both economic and political, which had developed under previous regimes. In order to implement its programme, the NRM therefore had to avoid direct confrontation and minimise conflict. The NRM's capacity to introduce radical reforms in the health sector was therefore potentially limited.

In addition, the extremely low levels of public revenue, combined with high defence budgets, limited the availability of funds available to the social sector. The high dependence on external aid to meet public sector deficits has meant that donors have been in a powerful position to influence government economic and social policy. As later chapters reveal, the health sector has been no exception in this respect.

3.0 RESPONDING TO THE HEALTH CRISIS 1986-1990

3.1 Introduction

This section describes and analyses the policy response to the inheritance of war from 1986 to 1990. The intermediate 'post'-conflict period in the southern and western districts, and the process of rehabilitation in the north and north-eastern districts between 1990 and 1993 is described in Section 4.0. While the imposition of time boundaries might be seen as somewhat arbitrary, it stems from the perception that the nature of the health policy dialogue began to change in the early 1990s as the impact of the earlier rehabilitation strategies began to become visible to the various actors responsible for policy design and implementation. There is no suggestion that these changes were sudden or clearly demarcated; the division is primarily an analytic tool.

Similarly, as the chapter aims to both describe and to analyze the determinants and the effects of policy choice on the health system, there is a risk that the framework for analysis imposes a false sense of order and "rationality" on the processes of policy development. As Foltz (1993) suggests, policy making is typically a series of ad hoc decisions which require constant renegotiation and realignment. The term "policy" is therefore meant in the sense that different actors within the health policy arena undertook a series of discussions, decisions and actions which influenced, or failed to influence, the health system, rather than being conceived as a discrete set of objectives realised through particular programme activities.

A final caveat. 1986 saw dozens of international agencies and hundreds of local NGOs instigating rehabilitation programmes, many of which had a direct or indirect impact on health. What follows cannot therefore be viewed as a comprehensive account of the rehabilitation process. Instead, it builds upon a more detailed examination of selected initiatives of the Ministry of Health and Local Government and three different international agencies: the World Bank, UNICEF and Medecins Sans Frontieres (Holland). The programmes of these organisations illustrate the potentials and constraints to the rehabilitation of primary, secondary and tertiary health services within different operational contexts. While this choice of focus cannot be described as representative in the strict sense, interviews with different informants suggest that they illustrate some of the major dilemmas inherent in the 'post'-conflict setting.

The remainder of this chapter is divided into five parts. The first reports on the methods and key findings of the analysis of the nature of the crisis inherited by the country in 1986. Section 3.3 describes the policy response to rehabilitation needs. Section 3.4 aims to analyse the factors which influenced the choice of policy, examining the respective roles of technical analysis, bureaucratic motivation, political support and international leverage in determining policy content. Section 3.5 analyses the factors influencing the process of implementation and the concluding part describes its intended and unintended outcomes.

3.2 Analysis of the Crisis

A study conducted in Uganda in 1987 suggested that "the limited nature of the information base precludes detailed policy analysis and planning. Rather there is a need for directional and aspirational terms of reference, since the destruction of files and medical records during periods of conflict makes longitudinal analysis impossible" (Lee et al, 1987). The statement is important because it underlines the acute scarcity of quantitative data upon which conventional approaches to policy design and planning rely. It also provides an indication of how the lack of technical information potentially increases the scope for other factors - political, bureaucratic and donor behaviour- to influence the process of policy choice.

The fora available to generate aspirational terms of reference were also limited: there was no political mechanism at national or local level to support health debate, academic institutions had suffered greatly

during the 1970s and early 1980s, and mechanisms for dialogue within and between donor organisations and government had not been established.

Thus, while individual agencies quickly became operational in many areas of the country, particularly in the worst affected areas of the Luwero Triangle, attempts to analyze the crisis from a national perspective in order to generate national health policies were restricted to two key initiatives. The first was the establishment of a National Health Policy Review Commission in September 1987 (Box 2). The second was a series of studies carried out under a Project Preparation Facility, sponsored by the World Bank (Box 3). AMREF, an East African NGO was sub-contracted to coordinate the studies and employed a number of consultancy companies and in-house staff undertake them. UNICEF's situation analysis was not published until 1989.

In addition to these two official studies, both of which served to create mechanisms for consultation between medical professionals, civil servants, politicians and district level officials, a workshop, supported by UNICEF, was held at Makerere University, which had sought to describe the extent of the health crisis associated with war and provided a forum for discussion regarding the possible direction of rehabilitation strategies (Dodge & Weibe, 1985).

The book resulting from the workshop (Dodge & Weibe, 1985) provides a comprehensive overview of the health situation in Uganda in the mid-1980s; this report provides only a brief outline of the state of the health system in the immediate 'post'-conflict period, in order to enable readers to gain a sense of the scale of the rehabilitation task.

3.3 Impact of War on the Health System

[Figure 3 summarises these effects, adapting a model for health systems analysis described by Roemer (1991) to reflect the impact of conflict on these systems.]

3.3.1 *Health Needs*

The decline in basic health indicators in Uganda during the 1970s and 1980s (Table 1) occurred during a period when the majority of other SSA countries were seeing health gains.

Table 1: Infant Mortality Rate (IMR), Child Mortality Rate (CMR) and Under 5 Mortality Rate (U5MR) in five year periods 1973-1988

	IMR	CMR	U5MR
1973-1977	91.9	96.5	179.6
1978-1982	113.9	97.0	199.9
1983-1988	101.2	88.1	180.4

Source: UNICEF, 1989

Dramatic reductions in per capita incomes occurred in the 1970s and early 1980s such that real incomes fell by 25%, while consumer prices increased by 1200% in the period 1970-1985 (Scheyer & Dunlop, 1985).

The collapse of the social infrastructure had differing effects in rural and urban areas. In urban areas, social services and amenities were eliminated or reduced, and a reduction in water and sewage disposal facilities led to an increase in water-borne diseases (Scheyer & Dunlop, 1985). In rural areas almost 80% of hand-operated boreholes were out of operation by 1979 due to lack of maintenance.

High rates of out-migration from towns to rural areas led to a reduction in the capacity of small farmers to feed extended families and a subsequent increase in malnutrition and related pathologies. Bond and Vincent (1990) record that the freeze in agricultural prices drew large proportions of crops into the parallel market so spreading the *magendo* into the primary food producing sector of the economy. The breakdown and illegalisation of transport mechanisms meant that low farm-gate prices were translated into high purchase prices by the time food reached urban areas. The long term impact of these processes on patterns of food production and distribution can only be guessed at. The *magendo* economy also had other health effects, including the increased tendency for men to travel across international borders to smuggle commodities: it has been suggested that *magendo* provided the "..economic and communications infrastructure of AIDS in Uganda" (Bond & Vincent, 1990).

The spread of the *magendo* was also linked with patterns of conflict, which itself has been associated with the spread of AIDS. Smallman-Raynor & Cliff (1991) argue that patterns of HIV infection in Uganda are strongly correlated with ethnic patterns of army recruitment after 1979. Their work suggests that rape and other changes in sexual behaviour in the context of war have an important impact on the pattern of STD transmission, including HIV. This point has been made in relation to other conflicts and the related high risk situations (Zwi & Cabral, 1991). The mental health impact of rape and other war-related stresses remain relatively under-researched. Giller et al (undated) have conducted preliminary investigations in areas such as Luwero, and found that victims of rape were less likely to be able to cope with their trauma than those who had suffered other forms of war-related stress. Amelia Brett (1992) has also conducted preliminary investigations into the prevalence of war-related stress. The findings of these studies conform with the interview material collected during this research: psychological distress was perceived to be a long-term consequence of war which was having an effect on physical health (manifest in reportedly high incidence of high blood pressure, ulcers and general malaise) and on social and economic recovery.

Only limited evidence is available concerning other particular health effects of war. Prevalence of disability from all causes was estimated between 2-5% of the population (Welbourn, 1991; World Bank, 1988). In both Luwero and Soroti, disability was seen as a major long-term health problem associated with the war. One informant reported that "...there are many people who have been left disabled because of gunshot wounds and other diseases such as tropical ulcers which were left untreated. Some people have been left blind and deaf from the measles epidemic" (Luwero interview). Another added that "...there were so many people who were left lame or blind because of shooting, beating and physical torture" (Luwero interview). At one meeting the nature of disability in the 'post'-conflict setting was described as follows "...one way of understanding people's disability is that people have not managed to achieve self-sufficiency in food because they feel physically weak and unmotivated" (Luwero, interview).

3.3.2 *Impact of Conflict on Health Resources*

The human resource base was dramatically affected by the indirect and direct effects of war, particularly at the senior levels. The expulsion of the Asian community in 1972, combined with the general atmosphere of insecurity and violence during the Amin years prompted a brain drain, which led to a fall in the number of doctors from 978 to 574 between 1967/8 and 1979, and of pharmacists from 116 to 15 in the same period (Dodge, 1986). An unknown number of doctors were killed, while others left the public health service to work in the private sector or in ministries, where they could attract better benefits, or to join rebel movements either as fighters or to provide medical support (interviews Soroti, academic, Kampala). The brain drain continued as doctors and other senior health professionals left the country to seek physical and economic security.

Senior planners and civil servants were also lost to the health sector, leading one expatriate adviser with considerable experience elsewhere in Africa to suggest that "..while the weakness in the public sector is not unique to Uganda, at the central level there is a particular problem because it was here that the brain drain was most acute during the periods of instability..[leaving] a problem in terms of middle and senior level management capacity within the country." A Ugandan health planner has

Box 3

Government of Uganda and the World Bank: First Health Project

The history of the First Health Project can be traced to a 1983 World Bank review of the health sector in Uganda, which highlighted the poor state of repair of the health infrastructure. Political instability and conflict prohibited more detailed appraisals and discussions until 1986, when negotiations were reopened.

A series of six background studies were conducted under a World Bank project preparation facility. These included: the identification of facilities for rehabilitation and maintenance; design of facility administration and training programmes; design of MCH/family planning programme; human resources and training needs assessment; cost-recovery for health services and supplies; support for planning and coordination of pre-project activities and project preparation, and a final synthesis of these sectoral studies.

The guiding assumptions & principles employed throughout the study were that the project should be sustainable with local resources; operate through existing institutions and not create new ones; and strengthen existing services before planning expansion. It acknowledged that the MOH affirmed PHC and stressed that "although concerned with rehabilitation this project is not aimed at recreating the health system Uganda had in the 1960s. Rather rehabilitation in the context of the proposed project refers to the development and implementation of a functioning health system, oriented towards equity and affordability". The documents highlighted the following risks anticipated with implementation of a rehabilitation programme: sustainability of project outcomes would depend upon substantial recovery of the economy; the recurrent cost burden of comprehensive PHC could not be borne by the government unless an effective cost recovery and financing system was implemented; the limited absorptive capacity of government was a major concern. It concluded that the large technical assistance programme would need to be carefully planned and phased out as Ugandan staff were trained.

It recommended the following project components: strengthening the MOH; development and support of national programmes and initiatives; addressing infrastructural inadequacies; human resource development; the development of district health systems – physical rehabilitation of hospitals and development of district systems for planning and implementation of PHC. Implementation of the project was to be overseen by an inter-ministerial steering committee. The total investment budget amounted to UShs 2,652 million = 44.2 million US$. The recurrent costs in addition to existing budget levels as a result of project initiatives and development were estimated at US$7.7 million.

Sources: Annett & Janovsky, 1988; World Bank, 1991; World Bank & Government of Uganda, 1992).

INCREASED HEALTH NEEDS

HUMAN, PHYSICAL & TECHNICAL RESOURCES

Diminished training & supervision of staff
Increased difficulty in attracting staff to work in peripheral areas
Emigration of skilled health personnel
Death, assault & repression of health workers
Destruction/neglect of health facilities
Looting of health facilities & supplies
Diversion of resources to provision of acute care for war-related health problmes
Reduction in knowledge base

Crisis approach to planning

Non-participation in international health debates

Disruption of lines of communication & referral

Insecurity leads to > physical isolation of health facilities

Breakdown health information system

Breakdown health management information system

ORGANISATION

Weakened civil institutions

Fragmentation of provision – rapid & uncontrolled privatization

Internationalization of welfare provision

Verticality of provision under relief/early rehabilitation model

Limited community capacity for management?

ECONOMIC SUPPORT

Reduction in central and local government health budgets effects of:

High defence budgets
Reduction in production
Illegalization of the economy

Greater dependence on external aid

Increased importance of private financing of health services

Increased poverty at household level – limited availability of cash

DISRUPTION OF HEALTH SERVICES

Disruption of routine disease monitoring & surveillance
Disruption of disease prevention & control programmes
Disruption case findings & community care
Fragmentation of provision -public, private
Increased focus on curative care
Urbanisation of provision

Adapted from Roemer, 199

blamed this lack of experienced senior staff for the slow pace of development of the national health plan. Work started in 1988, and a draft had been produced only by mid-1992.

These patterns were echoed at the district level. It was typically senior personnel who left, leaving relatively junior staff in charge of hospitals, health centres and management activities (Luwero & Soroti interviews).

The supply of lower cadres was also affected, particularly in those areas which saw the most intensive fighting. Health workers in Luwero district, for example, reported that many of their former colleagues had left the area in the early 1980s and failed to return. A similar situation was also reported in Soroti. "Three different factors affected the human resource base for health: some health workers who were not from Soroti, particularly Bantu health workers, fled because they were targeted by the rebels. Most of these fled the district.. they were often the most highly trained staff and prior to the war had made up 50% of the established staff. Others feared that they would be forced to treat rebels if they remained in the rural areas. If they had been caught doing so they would have been punished by the NRA so they came to the towns" (Member District Health Team, Soroti). In Soroti hospital "we currently have one doctor for a 250 bedded hospital; and even he is disabled by a war injury" (Member District Health Team, Soroti).

Several informants expressed concern that the problem was likely to intensify rather than improve over the coming years: the disruption of the education system, combined with high levels of poverty in the immediate 'post'-conflict period, has meant that relatively fewer children are leaving secondary school and entering university.

Physical Infrastructure

Like many countries in Africa, Uganda inherited a health system which favoured urban-based curative services. Unlike many of its neighbours which initiated community based services in the late 1960s and 1970s, the Uganda expansion of health services into rural areas in this period consisted largely of building district hospitals (Bennett, 1985). However, there was also a slow expansion of lower level facilities, and by 1970 the basic infrastructure for the delivery of health services to the majority of the population were in place, with nearly 60% living within 10 kms of a health unit (Dodge, 1986). The challenge since independence has therefore been to develop this infrastructure to ensure a sustainable and balanced health service for the majority of the country's population (ibid).

Health facilities throughout the country suffered from the effects of neglect and the absence of repair and maintenance programmes for nearly two decades. In those areas where fighting had been most intense, some health units suffered the effects of direct military action, while others were converted into military barracks, and many suffered the effects of looting, leaving them stripped of roofs, doors, locks, basic equipment and bedding.
A report prepared in 1988 suggests that the poor physical condition of hospitals and health centres rendered some of them barely functional, and argued that the scale of the damage was such that without additional financial and technical assistance, communities themselves would be unable to rehabilitate these units adequately (Annet & Janovsky, 1988). Thus, the remaining infrastructure in 1986 was a shadow of its former self and could be seen as the skeleton upon which the flesh of a health system could be rebuilt. According to this view, functional rehabilitation would be contingent upon achieving physical rehabilitation [4]. Alternatively it might be seen as the ghost of a former health system of limited appropriateness, which haunted policy-makers, politicians and local communities, and limited the development of more appropriate models for the health system.

Knowledge

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[1] "Physical rehabilitation" is defined as the restoration of the health infrastructure, including buildings and the replacement or repair of equipment. "Functional rehabilitation" is defined as restoring the health system - including resources, organisation, management and economic support - to a level where a minimum quality of care can be delivered efficiently and effectively.

The 1960s had seen vigorous and radical health debates in Uganda, and Makerere Medical School was home to some of the pioneering attempts to define and implement primary health care initiatives such as immunisation and growth monitoring. The chaos and disruption of the 1970s and 1980s carried a major opportunity cost in terms of health workers' access to international health debates, continuing education, and to the educational system as a whole.

As one informant suggested, the effect of a climate of political fear had served to "reduce the capacity to question and debate issues, including those around health" (interview, health academic). Dodge (1986) suggests that it was as if health debates and the policies they could inspire were frozen in the time that Amin came into power. While Uganda was represented at the Alma Ata conference in 1979, no fora existed or could be sustained to carry through the dialogue and translate it into a basis for policy (ibid).

In addition, training was interrupted as security broke down, the training infrastructure collapsed or was used for other purposes, and budgets decreased. In Soroti, for example, the nursing training college was turned into a hospital for people suffering from malnutrition.

3.3.3 *Economic Support*

Public Sector Finances

The collapse of the economy, and in particular of public sector finances, had an obvious and profound effect on government health expenditures. In 1986/7 central government support for health care in Uganda constituted only about 0.1% of GDP (Annet & Janovsky, 1988). Only 4% of public expenditure was allocated to health, roughly 25% of that found on average in other low income countries (Lee et al, 1987). What is most alarming about these figures is not their low levels per se, but the fact that in the past they had been much higher (Save the Children Fund, 1993). Tables 2 & 3 demonstrate both the fall in real levels of health expenditure as a percentage of GDP and expressed as a per capita figure:

Table 2: Real Ministry of Health Expenditures as a Percentage of 1970 levels, Selected Years 1970–88

Fiscal Year	70/71	82/3	84/5	86/7	88/9
Recurrent	100%	17.5%	22.0%	7.3%	16.9%
Capital	100%	8.2%	9.4%	4.7%	44.3%
Total	100%	14.5%	17.8%	6.4%	26.0%

Source: UNICEF (1989)

Table 3: Total and per capita Government expenditures on Health in 1988/9 expressed as a percentage of 1970/1 levels.

	Total 1988/89 MOH expenditure as % of 1970/1 levels	Per capita 1988/89 MOH expenditures on health as % of 1970/1 levels
HEALTH		
Recurrent	16.9%	10.5%
Capital	44.3%	27.5%
Total	26.0%	16.1%

Source: UNICEF, 1989

These figures need to be seen in the context of absolute falls in public revenue accounted for by the reduction in export of primary commodities as agriculturalists moved towards subsistence production, as the economy became increasingly informal and the state's capacity to collect taxes diminished. As well as declines in national tax income, the capacity for local authorities also diminished, reducing health expenditure at the local level.

The contraction in absolute levels of funds available for the health sector brought about a change in the pattern of expenditure such that the largest proportion of recurrent public funding (80%) went to personnel, allowing only limited room for other recurrent expenditures (Assiwme & Lule, 1993). This is a common budgetary response to financial stress, but one which is unlikely to promote goals of efficiency and equity (Cumper, 1993).

An AMREF report (Annet & Janovsky, 1988) notes the inequality of resource allocation between sectors and districts. Mulago hospital consumed 30% of recurrent and 70% of the development budget in 1986/7. Per capita expenditure on district hospitals ranged from Ush 2,500 to Ush 10,000, a pattern echoed at health centres where expenditures varied from USh 200 to Ush 1,500.

Private Spending on Health

In 1988 it was estimated that missions provided about 50% of health care (Annet & Janovsky, 1988). Private, out of pocket expenditures at missions and at other private providers – western and traditional – was estimated to account for four–fifths of total health expenditure in the country (ibid). Whyte (1990) provides a fascinating overview of the process of privatization of health provision in Uganda, and of the articulation between the private and public sector as public health workers sought to increase their incomes through informal charging and the establishment of private practice. Interviews conducted during the course of this research confirmed the findings of Whyte's paper that self–management, the most extreme form of privatisation, was often the only option available to communities whose access to western and traditional health services broke down under the conditions of extreme poverty and widespread displacement. One meeting described the situation as follows: "before the war the people used to seek health care from the health centre 7 miles away. While in the bush people had to rely on traditional herbs and others simply went without any form of treatment..... People returned to their homes in 1985 but at that time the health unit wasn't working...therefore people continued to rely on traditional herbs and those with emergency medical needs sometimes contacted the NRA barracks for medical assistance (community meeting, Semuto)."

Missions had proved more resilient to the impacts of conflict since their perceived neutrality meant that mission buildings and staff were not targeted by different factions, resources were available from external resources to sustain activities, and staff tended to share a religious motivation which

encouraged them to stay in often difficult situations (interviews). For example, workers at one public hospital reported that "At least two doctors left the public sector to work in the mission hospital; this was partly because they had been harassed by soldiers when they were working in the public hospital because they had treated rebels" (interview, District Health Team, Soroti).

By 1985 the missions accounted for 43% of the total bed complement, a 1985 and provided over 50% of inpatient care (World Bank, 1985). However, in some areas, the missions too broke down, staff fled and health facilities were used to house the displaced or soldiers (interview, mission hospital, Soroti district).

External donors

Prior to 1986 donor involvement in the health sector as in other sectors was minimal, but in the immediate 'post'-conflict period, particularly after 1987, donor resources became an increasingly important source of funding. The improvements in the operation of health services in the period 1986-88 was attributed to the rapid increase in aid flows from their 1982/3 levels of US$5 million to US$40 in this period (Annett & Janovsky, 1988).

The World Bank-funded studies concluded that Uganda faced a major crisis in health financing and stressed that it could only be resolved through an approach which diversified sources of finance for the health sector, and improved in the allocation and management of funds (Lee et al, 1987; Annett & Janovsky, 1988). The main report on health financing stressed that these could only be achieved through a "major restructuring of the health service" (Lee et al, 1987). It continued, however, "investment in health services is not starting from scratch - enormous investment has gone into the sector, much of this could be salvaged: a new cost-effective system must be sought and it is likely that this will be in the form of Primary Health Care provided by health workers close to the villages. However, the village level component will not necessarily be cost-effective without proper support; it can absorb great amounts of money without yielding results, and may be rejected by consumers. [However], immediate future investment in the renovation of hospitals is likely to show a very effective return, given the under-utilization of these services resulting from the poor service they currently provide. [A] relatively small investment now will mobilise previous investment in buildings, infrastructure and manpower which presently work to little effect...." (Lee et al, 1987). However, these expenditures could be seen as "sunk costs". Under this view, the appropriate question would be whether to increase investment in hospitals versus increasing expenditure in primary health care. Previous investment is irrelevant, other than indirectly insofar that it influences recurrent expenditure in the future (Mills, pers.comm).

The recommendations of the report therefore rested upon assumptions about the relative cost-effectiveness of two different potential strategies: one concerned with physical rehabilitation, the other concerned with restructuring the health system. However, no definition of "cost-effectiveness" is provided in the report. In particular, there is no discussion of the relative costs of different strategies over time and their recurrent cost consequences: the assumption that physical rehabilitation is more cost-effective than developing a system of community health workers and primary care facilities rests upon a comparatively short-time frame. The discussion also fails to take account of the equity implications of different strategies, favouring an analysis of efficiency criteria alone.

3.3.4 ***Management***

Policy

The formation of the Health Policy Review Commission (see Box 2) was motivated by the fact that as one member of the Commission put it "....for years policy was established by decree, no one knew what health policy really was, over the years it had become an ad hoc collection of declarations, rather than an integrated, legal framework for government action" (interview). The investigations of the Commission

itself confirmed the uncertainty surrounding health policy, and warned that "..even senior officers are not clear as to the Ministry's policy on specific issues..the absence of clear policies in turn leads to inadequate determination of priorities for the Ministry as a whole". It continues "..external donors take advantage of this 'policy vacuum' to lobby high political and civil circles, thus prejudicing policy decisions in their favour but not necessarily in the national interest" (Government of Uganda, 1987, p52).

Thus, while Uganda had seen a succession of policy reviews, conferences and workshops since 1962, none had ever been wholly implemented because of political uncertainty, lack of commitment and resources. The wide ranging Health Policy Review Commission reported that the public was weary of such processes, and called for many of the same recommendations voiced in previous documents to be implemented, in particular the findings of a 1980 committee which advocated the adoption of a Primary Health Care strategy.

The formation of the Commission provided an important opportunity for a reappraisal of policy. However, the terms of reference provided to the Commission focused primarily upon a review of existing policy documents, and did not link the policy and planning tasks. These two factors help explain why the Commission's report, which did not identify priorities for implementation, could not provide a basis for detailed planning. Instead, the recommendations of the Commission remained virtually ignored in the immediate 'post'–conflict period.

Planning

The absence of a clear policy framework had an obvious and profound impact on the capacity of public policy and planning institutions to act effectively. In particular there was a dichotomy between a system of incremental planning and the process of budgeting in an environment of contracting resources. This lack of linkage between the two processes meant that plans were largely paper exercises. Their limited value in guiding district levels activities was further limited by the breakdown in communications between the centre and the periphery which prevented the exchange of information between the Ministry of Health and the districts.

Despite the increase in population and the significant increase in health facilities, the office of the MOH itself had not undergone any significant change since its establishment in 1962. It therefore suffered from a limited administrative capacity compounded by poor management training and a fragmented information base (Annet & Janovsky, 1988).

3.3.5 *Organization*

The public health system inherited at independence was managed by the MOH and the MOLG and local administrations. The MOH was responsible for overall health policy, and for the functioning of all hospitals. It also paid the wages of established staff, including medical assistants and nurses employed in lower level health facilities. District Administrations were responsible for the salary costs of non–established (ie non–professional) staff at health units below the hospital level, the maintenance of health infrastructure and the provision of basic supplies. The MOLG provided a block grant to the DAs, which supplemented local government revenue to support primary health activities.

The nett result of the changes in the different components of the health system described above and in the politico–economic environment was a breakdown in health system organisation. The succession of predatory states since Obote's first rule had led to the increasing centralization of power, undermining the decentralized structures which had been laid down at independence. This in turn had increased the vulnerability of district level management when these central institutions collapsed and lost their own capacity to raise revenue and recruit and maintain qualified staff (interview, health planner, MOLG; Amnesty International, 1992).

The demise of public sector provision accelerated the degree of self-management and the rate of privatization of all types, and increased the importance of NGOs and missions as a source of curative care.

The NRM struggle had, however, created new institutions which offered the potential for innovation in the organization of health services. The RC system had been used as a vehicle for social organisation, including the delivery of relief supplies in the during the war and in the immediate 'post'-conflict period. However, in areas such as the Luwero Triangle, where the RC structures first developed, the organizational and political capacity of the system had been undermined by the counter-insurgency strategies employed by the Obote regime, which targeted RC members (Luwero, interviews). The capacity of communities to contribute to the organisation of the health system was also threatened by the effects of the war. Nalwanga Sabina (1991) writes "..experimentation in community participation which became popular elsewhere in Africa over the past 20 years is only now taking root in Uganda. Political turmoil put a halt to many development activities and sent people into apathy." Interviews conducted in Luwero and Soroti suggest that the war did undermine people's willingness to organise collectively for development, both because of the distrust it created within communities and because the physical demands of household rehabilitation limited the availability of time and finances for community-based activities.

3.3.6 *Health Services Activity*

Service delivery was critically undermined by the impact of war. In theory the health system which had developed prior to 1970 was a balanced one which aimed to provide both curative and preventive services. In practice, it emphasised curative care delivered through fixed health units, and the majority of resources were directed to hospitals.

By 1980 it was barely functioning. The displacement of populations and of health workers, the relatively inaccessibility of government supplies, meant that health service provision became even more urban-based than had been the case in the pre-war era (Soroti interviews; Luwero interviews; Assiwme & Lule, 1993). In both the districts visited there were reports that in the rural areas there had been a complete breakdown of health services as staff fled and logistical networks broke down.

UNICEF had reestablished its Expanded Programme of Immunisation in 1980, which was revived at an accelerated pace in 1986. In 1987 only 33% of children had received measles vaccine; 20% DPT3 and 50% BCG (UNICEF, 1989). The Uganda Essential Drugs Management Programme, funded by Danida and implemented by the Danish Red Cross, followed a similar pattern of development. It was initiated in the early 1980s, disrupted as violence increased, and then restored and rebuilt after 1986.

These two vertical programmes have provided the major inputs to primary health services since 1980. Other aspects of preventive care, such as vector control had broken down during the 1970s and had not been revitalised in the rehabilitation period of the early 1980s, remaining inactive by 1986. The demand on service providers for curative care increased during the periods of instability as injuries increased, as did the need for treatment for diseases of poverty.

The fragmentation of service delivery continued in the immediate 'post'-conflict period as these organisational, political and economic factors which promoted urbanisation, privatisation and a shift in favour of curative care persisted, and the number of other actors on the health scene increased, particularly NGOs.

3.3.7 Summary Section 3.3

The pre-conflict health system in Uganda was not appropriate to the needs of the majority of its population and is unlikely to have been sustainable even without the catastrophic impact of conflict on the country's economic base. Conflict served to exacerbate rather than create the structural weaknesses in the health system, and also led to a dramatic increase in poverty and specific health

problems, including massive psychological stress and war-related disability, and created increased vulnerability to ill-health among groups such as orphans, widows and persons with AIDS.

The capacity of the national health system to deliver an effective health response to this crisis was undermined by the direct effects of economic and political crisis, and compounded by the opportunity costs of war which proscribed Uganda's participation in international health debates.

Two major studies dominated analysis of the health sector in this period; both of these simultaneously advocated the restoration of the health service to its pre-conflict levels of financing and the expansion of PHC services.

3.4 "Policy" Responses to the Crisis

Frenk (1993) has made the distinction between systemic and programmatic policy. The former comprises a macro-framework, typically at the national level, which lays out the main objectives of the health system. Policy at the programmatic level, under Frenk's typology, is concerned with operationalising sytemic policies.

In the period 1986-1990 no effective systemic national health policy was in place to guide the development of national or international rehabilitation activities. International agencies responsible for programme financing, design and implementation operated within their own organisational policy frameworks, which reflected each agency's international policy objectives. The policy arena can therefore be described as essentially fragmented, comprising of "micro-policies" linked to specific programmes and projects. The term "policy" response should not therefore be seen as a homogenous whole, but rather as a set of decisions taken within different organisations, each of which then implemented a series of non-integrated programmes and projects. These individual rehabilitation programmes were not coordinated, nor in the absence of coherent public policy, was each of them contributing to overall strategic policy goals.

In the period 1986-7 there was only the most limited capacity to effect coordination, in particular between the MOH and the MOP (now MFEP)(interview MFEP official). The implications of this projectisation or compartmentalisation of health programmes are discussed in more detail below in sections 3.4 and 3.5.

Table 4 provides a list of the major projects included in the Rehabilitation Plan 1988/9. This revised version of the 1987/8 Plan is used since it reflects more accurately the plans underway during the immediate 'post'-conflict period. While the list of projects contained within the Rehabilitation Plan reveals something of the broad sweep of projects introduced in the immediate 'post'-conflict period, it fails to indicate both the manner of implementation and the relative shares of government and donor financing. In particular, it does not capture the duality of responsibilities between donors and government which emerged in this period with respect to the primary, secondary and tertiary sectors, and to capital and recurrent expenditures. Two key projects provide an illustration of these phenomena in this period. The Uganda National Expanded Programme on Immunisation (UNEPI), supported by UNICEF and SCF(UK), and the First Health Project, funded by the World Bank. These are described briefly below and serve to indicate the respective difficulties of rehabilitation of primary health care facilities and tertiary facilities in Uganda.

Uganda National Expanded Programme on Immunisation (UNEPI)

Immunisation services had started in Uganda in the early 1970s, but by the end of the decade they had virtually collapsed (UNICEF, 1989). Activities were revived during the early years of the Obote II regime, but were once again interrupted by insecurity. In 1986 a tripartite agreement was set up between the Ministry of Health, UNICEF and Save the Children Fund

Table 4: List of Health Sector Projects listed in the 1988/89 development plan

Project Title	Objectives	Cost US$ millions	Funding Agencies
Physical rehabilitation			
Rehabilitation of Mulago Hospital	Physical Rehabilitation of main teaching and curative facilities	28.2	ODA, African Development Bank
Strengthening of Primary Health Care Services	Physical rehabilitation of health centres; CDD, MCH, Health education, assessment of women's needs	39.40 [5]	UNICEF, WHO, USAID, Denmark
Rehabilitation of government district & rural hospitals	Physical rehabilitation of 44 government run hospitals	23.62	West Germany, UNDP, Norway, ADB
Installation of Hospital Radio calls	Improve communications between hospitals & ambulances	0.70	no donors
Other			
Essential Drugs Management Programme	Provision & distribution of essential drugs	34.2	DANIDA
Accelerated Immunisation Services	Reduction of child and maternal mortality rates through expansion of immunisation	28.0	UNICEF, SCF, Italy & others
National Population Programme	Reduce annual rate of population growth	11.94	UNFPA, World Bank, UNICEF, Japan
National Aids Prevention & Control Programme	Survey & monitor AIDS epidemic, strengthen preventive programmes	18.29	EEC, Denmark, West Germany & others
Health Training & Planning	Rehabilitation of training schools for rural health workers & provision of training	18.54	CIDA
Total:		202.89	

[5] The majority of these funds were spent on capital costs, but it remains unclear what proportion of these went specifically to physical rehabilitation of health units and what to other items.

(UK) initiated an accelerated programme of immunisation in order to expand coverage nationally.

The initial objective of the programme was "..not focused on physical rehabilitation of health units [6], but more on functional rehabilitation, on getting things moving...Therefore UNICEF provided equipment, training and logistical support to enable the reestablishment of immunisation services" (UNICEF official). The programme worked on a bare minimum of requirements based in small facilities and implemented by trained government health staff and in partnership with NGO units. UNEPI was seen as the potential platform from which a broader programme of primary health care could be developed as the basic human and physical infrastructure was rehabilitated. As in other countries, selective interventions were seen as an interim measure on the road to comprehensive primary health care at a time when resources were limited (Walsh & Warren, 1982). Save the Children Fund provided all the technical expertise for the programme, with a total of eight staff, four of whom were based in the central EPI office based at the MOH. UNICEF provided funds and one logistical officer, based at UNICEF office in Kampala, and provided allowances to health workers involved in the programme on the basis of work performed.

UNICEF also supported other similar vertical programmes such as control of diarrhoeal diseases (CDD) and the rehabilitation of water and sanitation.

World Bank/GOU First Health Project

As described above (see Box 3), a series of project preparation studies were conducted over an eighteen month period, commencing in 1987. While the project preparation period was lengthy when compared with the pace of implementation of other projects, in World Bank terms the turn around period from preliminary discussions to IDA commitment of funds was relatively fast – only 9 months (World Bank official). The main components included in the final project document were the rehabilitation of 9 hospitals and 33 health centres, and the construction of one new hospital[7] (total budget US$36.9 million); the promotion of preventive health programmes for an estimated population of 500,000 (US$10.3 million), and the development of planning, monitoring and evaluation capacity, and analysis of alternative health financing schemes (US$3.5 million). The emphasis of the final project is therefore very much on physical rehabilitation rather than the more broader objectives proposed in the project preparation documents.

Initially the physical rehabilitation element of the project was to be implemented by the Ministry of Works, however, it quickly became clear that this ministry lacked sufficient capacity and a Project Implementation Unit was set up in Entebbe outside of the MOH and Ministry of Works structures.

The type of finance available to the primary sector was substantially different from that which supported secondary and tertiary activities. For example, UNICEF's support for UNEPI was in the form of grant aid, while the First Health Project was financed by a loan, albeit on concessional terms. Thus, "ownership" of programmes was, in strict financing terms at least, split between an external agency (primary health care services) and government (secondary/tertiary health care services).

The two projects also demonstrate a second important characteristic of the overall rehabilitation programme, namely a significant level of dependence on external aid for both capital and recurrent expenditure. Figures for the respective shares of capital and recurrent expenditure from donors and

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[6] However, GOU documents indicate that UNICEF were involved in the rehabilitation of over 100 health centres (GOU, 1989)

[7] By 1992 it had been decided that the proposal to build a hospital in Rakai should be dropped in favour of supporting lower level health units. This was partly a reflection of the significant overspend in the budget, partly of changing World Bank and MOH priorities for health development.

external agencies are difficult to obtain for this period for a number of reasons. Firstly, because of the lack of consolidated figures for aid receipts; the Ministry of Finance and Economic Planning is only now beginning to produce such figures. Secondly, as described in more detail below, donor preference for supporting capital over recurrent costs, has led to the practice of "disguising" recurrent expenditure in development budget lines. Save the Children Fund (1993) have produced figures for 1990/91 which provide a picture of the respective trends (see, Figure 4).

An additional feature of these projects and many other related initiatives is that they sought to replicate or extend programmes which existed in the period prior to 1986. Both UNICEF's EPI and DANIDA's Essential Drugs Management Programme, the two key vertical programmes supporting primary health services were revived versions of those implemented in the early 1980s. While such programmes are common to many other countries, what is striking is that their design paid only limited attention to the particular context within which they were implemented – in particular, the extreme weakness of the other aspects of the health delivery system. Similarly, the World Bank programme built upon the government's wish to rehabilitate the health infrastructure which had existed prior to 1970. A second striking feature of the rehabilitation initiatives planned in the 1986/7 period is their similarity to the rehabilitation plans prepared in the early period of the Obote II regime in the early 1980s. The National Recovery Plan 1982–4 identifies seven health sector projects, 6 of which feature in the 1988/89 development plan [8]. The implications is that the earlier document was "lifted off the shelf" and used again, once conditions permitted.

The key question then is, why, given the known depth of the economic crisis inherited in 1986 and the estimated costs of trying to replicate it, did the government and donors support health policies which were likely to be unsustainable in the short, medium and long term?

It is important to stress that the resources available to the MOH in 1986 were only 6.4% of their 1970 levels. In the early 1980s Scheyer & Dunlop (1985) developed a number of methods to calculate the increase in public sector budgets required to replicate the pre-conflict health system. They are worth quoting at some length since they provide an insight into possible methods of estimation and provide a good indication of the scale of the financing crisis being experienced by the health system:

These authors pose the question "how much would the government have to spend to restore the health care system to its 1968/9 levels of functioning?". The calculations employed only give an estimate of recurrent costs. These calculations were made in the early 1980s, thus the figures are not equal to those reported for 1986. Given that economic performance continued to deteriorate during the 1980s and that the physical infrastructure had deteriorated still further by 1986, it is probable that these figures represent an underestimate of the costs likely to be incurred in 1986. However, the figures do provide an indication of the magnitude of the crisis. Scheyer and Dunlop propose three possible ways of answering the question:

a. Identify the actual levels of expenditure in 1968/9; equalise the shilling rate prevailing at the current time and estimate what increase in government expenditure would be required to meet this level. This type of calculation would make no allowance for increases in utilization rates or population growth. Their calculations, which compared the levels of actual and required expenditure in 1968/9 with that in 1979, suggest that total government expenditures on health would have had to increase 5.84 times.

b. The second method does take account of population growth by comparing per capita government expenditure on health in the two periods. This approach suggests that

[8] The projects were: rehabilitation of Mulago hospital; rehabilitation of 45 government district & rural hospitals; rehabilitation of 445 small rural health units*; establishment of blood transfusion services**; strengthening of primary health care services; health training & planning; accelerated immunisations services. (* included in 88/89 plan under different heading; ** not included in 1988/89 plan).

even in 1979 that government expenditure would have had to increase 11.2 times to meet 1968/9 levels of provision.

c. The third option equalises expenditure per visit and the utilization rate per capita existing in 1969, thus also taking account of population growth. In this case, total 1979 expenditure would need to have been increased 12.45 times. While the authors suggest that this ignores the potential economies of scale, they sought to compensate for this by employing a lower target figure for utilization rates than that found in 1979.

The question of why the financing issues were largely ignored by both government and donors is particularly puzzling because the timing of the rehabilitation programme coincided with a period of international debate regarding health financing, led by the World Bank, which focused upon issues of financial sustainability of the health sector in a climate of adjustment and reform (World Bank, 1987). Yet one informant has suggested that the underlying assumption within both government and donor circles was that aid flows would continue indefinitely, and even increase over time (NGO representative). In other words, while donors were internationally concerned with health financing issues, they were enthusiastically committing substantial sums to the health sector in the immediate 'post'-conflict period and to be seen as the primary supporters of reconstruction of the health sector. This uncritical support by donors for the government and NGO health services may have served to mask the extent of the health financing crisis, and so deflect discussion of the need for radical restructuring and reform of the health system.

Not only issues of health financing were ignored however: nearly a decade of international health debate had ensued following the Alma Ata conference which had challenged exactly those paradigms of health delivery which had dominated the health system in the pre-conflict era in Uganda. While the role of Primary Health Care in improving health status is mentioned in all of the key documents prepared at this time, the overriding assumption of both the Health Policy Review Commission and the World Bank-funded studies is that PHC would follow from physical rehabilitation of the health infrastructure at secondary and tertiary levels. Yet it is unclear *how* this was to be promoted or achieved. Similarly, with regard to the establishment of vertical programmes such as EPI, this was seen as the basis from which an integrated system of health delivery could be achieved in the future. Again, there was no indication of how this was to be done; in 1986 a considerable body of literature already existed which challenged the validity of this assumption based on experience worldwide (see for example Rifkin & Walt, 1986; Gish, 1986).

There was a division of responsibility across sectors, with donors and NGOs dominating the financing and provision of preventive and basic curative primary health services, and government taking responsibility for personnel costs and secondary and tertiary facilities. However, a common feature of both was on rehabilitating and restoring the health infrastructure, or more broadly, health *hardware* (buildings, vaccines, drugs), rather than on addressing the wider structural problems in the health system – physical and financial resources, organization and management. It might be argued that the nature of the crisis was misconceived at this time, insofar that it was seen as *infrastructural* rather than *structural*. This is not to suggest that the physical infrastructure was not in urgent need of repair, rather that this issue dominated debate and served to mask wider, deeper and equally critical problems which had existed prior to successive conflicts, and which political instability and the associated economic crises had exacerbated. The limitations of the overemphasis on the infrastructural component of the health system is acknowledged by the World Bank's own mid-term review (World Bank & GOU, 1992).

The response of donors and government therefore did not address two central issues: the financial viability of Uganda's health system, which had been raised by a succession of reports dating back to the 1970s (Scheyer & Dunlop, 1985; Dodge, 1986; Lee et al, 1987) and, perhaps more fundamental, its organisation and objectives.

3.5 Towards an Explanation of the Policy Response

This section aims to understand why these policy choices were made and so to identify possible policy spaces which might have been open to influence and change by different actors in the rehabilitation process in Uganda, and which offer potential in other similar situations.

The section is structured using the framework provided by Grindle & Thomas (1991) which groups factors influencing policy choice as: technical analysis, political stability and support; bureaucratic capacity and international leverage. Through this analysis the discussion also highlights factors which condition the attitudes and practice of policy elites. These include factors such as personal attributes and goals, ideological predispositions, professional expertise and training, memories of similar policy experiences, position and power resources, and political and institutional commitments and loyalties (Grindle & Thomas, 1991, pp35–37). These are perhaps the most difficult features of the policy environment for an outsider to gauge. Table 5 attempts to summarise the more obvious of these features separately from the other four principle categories outlined above.

3.5.1 The Role of Technical Analysis

Three key questions present themselves when trying to understand the role of technical analysis in policy formulation in the immediate 'post'–conflict period: i) what capacity existed at the national level for technical analysis?; ii) what types of data were collected, by whom and why?; iii) Was technical data used to inform policy choice? If so by whom and why; if not, why not?

Capacity for Technical Analysis

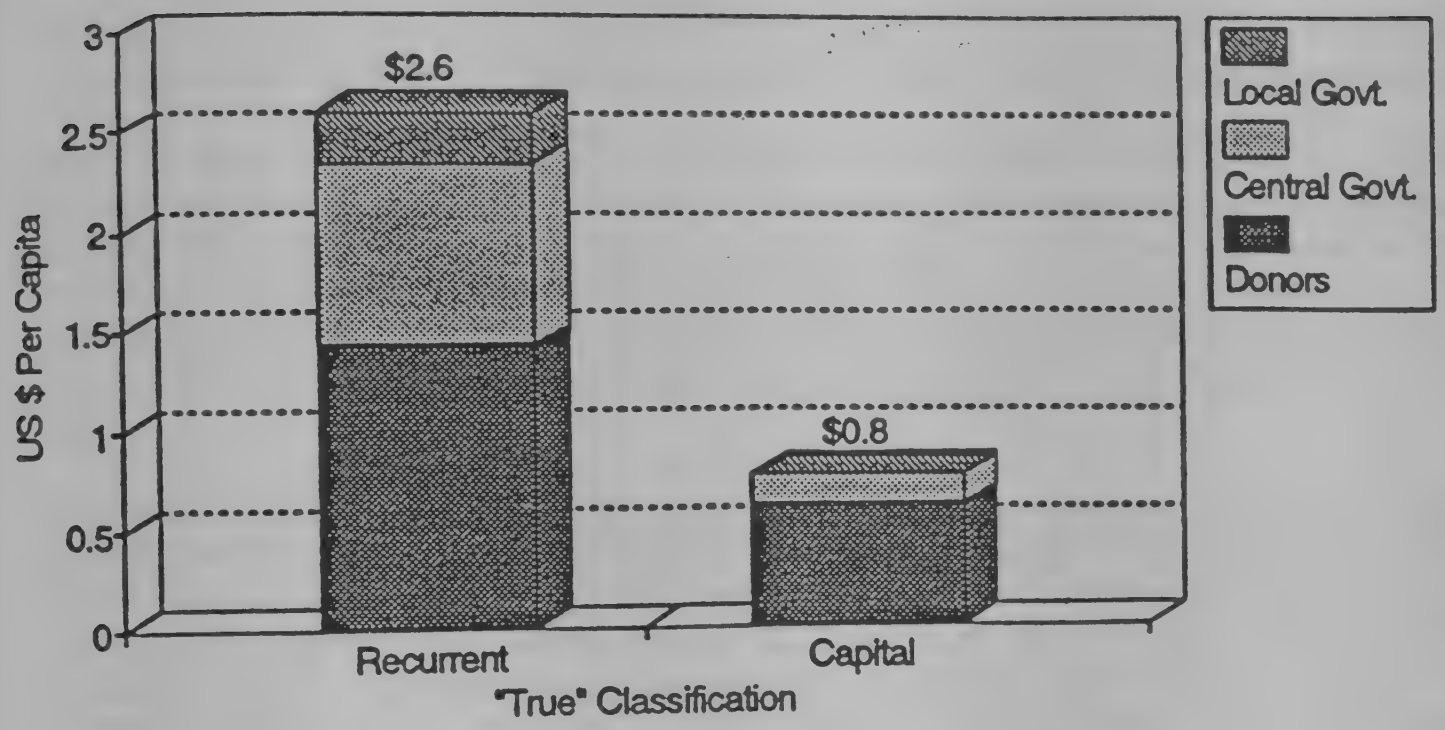
The rehabilitation of the health information system as a basis for policy analysis was slowed as donors by–passed government institutions and collected and utilised their own data. Thus the health information system developed in the immediate 'post'–conflict period became geared to the requirements of donors, rather than those of national government. So, for example, considerable information was available regarding EPI coverage, but very little regarding human resources, and information tended to be "patchy" according to donors' areas of operation (Health Planners, MOH, MOLG; Dodge & Henderson, 1985).

Within the MOH itself, there was only one planner, himself an expatriate, and the ministry contracted an NGO (AMREF) to coordinate the background studies for the First Health Project. Thus, national capacity to undertake nationwide studies at this time was extremely limited.

Boxes 2 and 3 above showed the two major national health sector reviews which were conducted nationally. The Health Policy Review Commission comprised of Ugandan nationals, largely drawn from the medical profession, but supported by an international health expert, who acted as a facilitator. UNICEF provided financial support to the Commission, covering the personnel, transport and report preparation costs. While the report provides a valuable overview of the health system, it lacks comprehensive quantitative analysis of health needs, financial resources or available levels of human resources for the health sector. Perhaps more importantly, it does not develop alternative policy scenarios.

In the immediate 'post'–conflict period there was therefore limited national capacity to generate data which could highlight the implications of different policy choices. International agencies and the consultants they employed tended to reinforce the closed nature of the policy debates by circumscribing policy questions within their own domain of interest, rather than initiating more fundamental debate regarding policy options. The questions asked in this period conformed to the imperatives of national political priorities and the organisational requirements of donors, but were, in many senses, inadequate to the challenges facing the sector.

Figure 4: Financing Public Health Services 1990/1



Source: Save the Children Fund, 1993

Types & utilization of data

In contrast to the review of the Health Policy Commission, the six background studies for the First Health Project were prepared by international consultants from a wide range of backgrounds including health economics, engineering and health planning. They provide a rich body of quantitative data regarding diverse aspects of the health system. Yet there is a sense that the terms of reference within which consultants were working tended to focus down the appraisal task in favour of one primarily concerned with the restoration rather than redefinition of the health system (Dodge, 1986). For example, engineers' reports typically advocate the rehabilitation of the physical infrastructure to pre-conflict standards, but do not propose alternative building materials or architectural designs to provide facilities which might function equally well. Similarly, the health financing study highlights the risks of a strategy which focuses primarily on physical rehabilitation of secondary and tertiary facilities, but fails to identify alternative options which meet its own criteria of cost-effectiveness.

The recommendations of these reports which, even in the absence of basic data, were used by planners to focus the planning task down to one primarily concerned with physical rehabilitation.

The narrowness of the policy agenda was also maintained by bureaucratic attitudes to the planning task. For example, one senior planner suggested that "..physical rehabilitation only involves an assessment of requirements and this is mainly done by quantity surveyors. A developmental programme is more challenging and requires technical justification. Physical rehabilitation is just like repairing an old house, planning is not necessary, what is required is to repair it to the old design. There is very little required in terms of technical skills, it is not planning for the future, but repairing what is lost ".

In other words, fundamental issues regarding where priorities in the health sector should lie remained unasked because there was seen to be a conceptual difference between rehabilitation and development planning. They were not perceived as integrated and related tasks, but as successive actions with different goals. Again, this failure to examine fundamental issues is not unique to Uganda – the slow response of governments internationally to the recommendations of Alma Ata indicate the difficulties inherent in reorienting health systems in favour of PHC (see, for example, Segall, 1983). However, given the extent of the health crisis in Uganda in 1986, and the long-term implications of adopting different rehabilitation strategies, the absence of a vigorous debate in the immediate 'post'-conflict period regarding the direction of the public health service was to have particularly profound implications for health development in that country which are only now being felt.

The lack of linkage between rehabilitation and development is demonstrated by the startling lack of attention paid to the recurrent cost implications of rehabilitation programmes. One World Bank informant explained this as follows "..there was an assumption that because the programme was rehabilitating structures rather than creating new ones, the future recurrent cost burden would not be increased." This neglect of recurrent cost implications of substantial development budgets has apparently been a feature of rehabilitation planning across sectors (World Bank official), as one of its officials put it "now (1993) development expenditures have reached unsustainable levels, but the recurrent cost implications are still not taken into account." A Ugandan health planner has suggested that the time-frames imposed by donors limited the capacity of government officials to prepare accurate estimates of recurrent costs. Because planning had to be done to coincide with donor budgetary cycles, there was simply insufficient time to produce the complex calculations required to estimate the future costs associated with large capital expenditures.

Use of Technical Data

Most of the reports and documents prepared in this period highlight the risks to financial sustainability of a strategy primarily designed to achieve physical rehabilitation of the health system. The consensus among planners working within the ministries responsible for health development and outside government institutions is that technical analysis was not taken seriously by politicians responsible for

Table 5: Summary of Factors influencing policy choice in the immediate 'post'–conflict period 1986–1990

	Factor
Attributes of policy elites	Curative model of health provision highly valued
	Professional expertise and training had encouraged incremental approach to planning centred on curative care provided in hospitals
	Strong memories of pre–conflict health system, rehabilitation plans formed after Obote II had supported strategy of replication rather than redefinition of health system
	Fragile political relationship between bureaucracy & the executive
Technical Analysis	Extremely low information base
	Limited national capacity for technical analysis – policy & planning
	Limited national fora to debate terms of reference for policy review
	Limited national ownership of data collected – fragmentation of data collection
	Data collected conforms to needs of donors rather than to national data priorities
	Failure to calculate recurrent costs
	Fast rate of technical analysis limits quality of data
	Delay in utilising data collected, reducing its usefulness
	Limited political interest in technical analysis
	Top–down, rationalist approach to planning and policy design – limited participation from districts, rural communities; limited analysis of constraints – economic, political, bureaucratic to implementation and sustainability
Political stability & support	Limited preformed political agenda for health
	Limited political space for discussion of health
	(Perceived?) popular demand for restoration of curative services
	High degree of compliance with bureaucratic advice
	Political influence of medical professionals
	Political support for physical rehabilitation and SPHC
Bureaucratic Motivation & Capacity	Swollen bureaucracy – numerically large
	Entrenched attitudes to planning health services as an incremental process
	Limited impact of previous policy reviews because of lack of political interest
	Low pay, morale and skills
International leverage	High levels of aid dependency – reluctance to coordinate activities
	Donor preference for projects over policy
	Preference for vertical programmes to ease administrative requirement Donor preference for capital over recurrent costs
	Administrative requirements of donor institutions
	Attempt to implement universal policy paradigms
	Conformity of interventions to areas of agency expertise rather than to needs

endorsing policy and allocating resources (WHO official; MOH official). The World Bank itself is reported to have rejected the reports prepared under the Project Preparation Facility and to have ignored several key recommendations of the preparatory reports, particularly those concerning the need to rebuild district level capacity (WHO official). Part of the difficulty for those responsible for technical analysis as part of this programme was that the credit agreement for the First Health Project was completed before all the planned appraisal exercises had been implemented, exposing project staff to pressure to implement activities without confirmation that this policy direction was appropriate (World Bank official).

It is important to note that the lack of national capacity to generate alternative options for health development meant there was limited technical justification available to resist the political pressures outlined in more detail below. In addition, the prevailing attitude among planners within national ministries seems to have implicitly supported the choice of rehabilitation agenda. As one informant put it ".. the orientation to problem solving at the policy-making level is a reflection of the medical approach to curative care; it focuses on the immediate problems in front of you while ignoring the wider environment" (expatriate academic) In other words, the process of technical analysis had to some extent already been shaped by the assumptions of health planners involved in the process of technical appraisal. Again, this emphasis upon a rational, empirical approach to planning is not particular to 'post'-conflict settings, it is perhaps rather a reflection of western models of education and planning paradigms. However, there is an increasing awareness of the need to broaden analytical techniques to include an understanding of the interrelationships between different facets of health systems, and of the impact of the wider political and economic environments on their development (see for example, Cassells, 1992). In 'post'-conflict situations, such as in Uganda, where the information base is particularly deficient and where public policy is essentially inoperative, the limitations of conventional approaches to problem solving are likely to be particularly acute.

3.5.2 *Political Stability & Support*

1986 saw a change of regime and a commitment to a radical change in the system of governance, embodied in the Resistance Councils. The NRM's process of transformation from a guerrilla movement to state power was hampered by four mutually reinforcing factors: the development of armed opposition movements in the north; the need to ensure a broad-based government in order to maintain national unity; established interests and practice within the bureaucracy; and the relative weakness of popular support and local level political consciousness.

The government was faced with the task of rebuilding a country whose economic and social infrastructure had collapsed. The restoration of the health infrastructure was perceived at all levels to symbolise a process of normalisation and part of a wider process of Uganda's return to its pre-1970 level of social and economic prosperity. Memories of the past have therefore been a powerful factor in determining policy choice and help explain the political pressure faced by those within the executive, donors and NGOs who were perhaps less sanguine of such a strategy.

Attending to the health agenda was not, therefore, without political capital. While key political members of the health executive are reported to have been wary of adopting a strategy which concentrated on physical rehabilitation, members of the National Resistance Council and local politicians are reported to have lobbied for the reconstruction of local health facilities, particularly hospitals. NGOs too faced pressure from local communities to rehabilitate physical structures (NGO representative). It is clear, both from interviews at the national level and from meetings with local communities that many people recalled the previous health system and valued highly the curative services they received. The provision of health services is seen as a government responsibility in Uganda (Welbourn, 1991). The level of popular expectations for the restoration of the past system is therefore likely to be relatively higher than in countries where the public health system was poorly developed in the pre-conflict period, as for example in Somaliland (Forythe, pers.comm). It is difficult, however, to determine whether

politicians who lobbied for rehabilitation of the physical infrastructure were reflecting the opinions of the majority of their constituents, particularly the rural poor, or simply their own perceptions of priorities.

Aside from restoring facilities, high profile vertical programmes also served a political function. One informant suggested that "..EPI was perceived politically to be part of the demonstration of how they [the NRM] could reach various parts of the country. By encouraging UNICEF and SCF to inject monies into it, the government was able to show that they were doing something to save the children in all corners of the country" (NGO representative). Vertical programmes were also attractive to the donors: they could carve out a particular role, assume responsibility for this area of activity, and set up staffing, managerial and information systems to achieve their objectives. The justification for donors taking on such a direct role in the provision of services was that national capacity for the design, management and implementation of programmes was very weak.

Overall however, health did not occupy a prominent position on the political agenda during the period 1986–1990. The NRM had executive secretaries for functions such as defence and education, there was no such representative concerned with health. The early rehabilitation plans formulated in 1987 and 1989 were based on the premise that the rehabilitation of the social sector would follow the process of economic recovery. Neither health nor education were identified as being among the eight priority areas of the economic recovery programme in the President's address at the state opening of the first session of the expanded NRC in April 1989 (pers.comm, government health planner).

One informant has also suggested that in situations where security remains precarious, it might be easier to raise donor resources for the health sector, where interventions are seen as essentially humanitarian in nature, than for agriculture and transport which are perceived as more closely linked to the national political economy. Relatively high donor interest in the health sector might therefore allow government to pass over responsibility for this sector while concentrating its own energies elsewhere (NGO representative).

While it can be argued that communications and agricultural production may contribute significantly to health development, it is apparent that the NRM lacked a clear political agenda for health. The only commitment in the 10 point plan directly relevant to health was to rehabilitate the health infrastructure; even this was given only limited political priority.

One aspect of the health system was, however, particularly politically sensitive. The Health Policy Review Commission had recommended the formation of health unit management committees. These were seen as a potential vehicle for greater community participation in health service delivery and as a structure to introduce and manage limited community financing. The formation of these committees was encouraged by the MOH, as recommended by the Health Policy Review Commission, but no clear guidelines were issued to them, particularly regarding their role in setting and collecting fees. The National Resistance Council rejected the introduction of fees, and the primary role of the Health management committees was therefore seen as meeting other, albeit unclear objectives. Political intervention was therefore a constraint to the development of alternative systems of health financing in the immediate 'post'–conflict period.

Influence of Medical Professionals

Doctors also constituted a significant political pressure both within and outside government. A number of physicians occupy key positions in government, and the large majority of members of the Health Policy Review Commission was drawn from the profession. In addition, Makerere University in general, and the Medical School in particular, hold a peculiar and powerful influence in Ugandan life, allowing its members to enter and strongly influence top policy circles (interviews expatriate and national health professionals and planners). While many of these endorsed the principles of PHC, they also lobbied for the continued emphasis on curative care. A member of the Commission remembers that "lobbying from the medical profession was largely with regard to Mulago". While Ministry officials recognised the hazards of allowing and encouraging the dominance of medical professionals in the policy debates at

this time, they also point out the lack of alternative fora for debate from which other interests and opinions could be sought (MOH official).

3.5.3 *Bureaucratic Motivation*

The civil service inherited in 1980 is estimated to have comprised over 250,000 workers and was not substantially reduced in the period to 1986 (Commonwealth Secretariat, 1979). While the majority are described as unskilled, the bureaucracy had survived and even flourished under previous regimes as the civil service was used to reinforce state power. While employment within the civil service brought important benefits, such as housing, and access to resources such as drugs and licences, low salaries forced its employees to develop alternative strategies of survival. These often had negative consequences for the functioning of the public sector.

The government had to be cautious in challenging the status quo: it was dependent upon the civil service functioning to implement the government programme of political and economic reform. It was therefore forced to work through a bureaucracy perceived to be resistant to political change and subject to corruption (Burkey, 1991; interviews expatriate advisers).

In the health sector the government was perceived as handing over responsibility for health policy to bureaucrats, and to be "..compliant with the bureaucratic machine" (Health Planner, MOH). Some key bureaucrats see their work as having been unaffected by the change of regime. As one put it " planning is a technical process and is not badly affected by political change – when there is a change in government the technical staff in the ministry remain the same. Technical aspects do not change dramatically" (MOFEP official).

The bureaucratic machinery itself lacked the capacity for effective and efficient planning and analysis. It is only in the most recent rehabilitation plan that a clear mechanism for priority setting and rationalisation of sectoral development is set out (Government of Uganda, 1992a), in 1986 there were no central review and control mechanisms in place. The budget submission from the MOH is reported to be particularly weak. The Health Policy Review Commission (Government of Uganda, 1987) described the failure of the Ministry to conform to budgeting guidelines and criticised the poor quality of its submissions, a problem which continues to haunt the MOH (SCF, 1993).

The role of bureaucrats in determining policy choice therefore appears linked both to motivation and to capacity. Low salaries within the civil service meant that public sector workers needed to diversify their sources of income. This rendered the civil service as a whole particularly vulnerable to corruption, and meant that public sector workers spent considerable energy securing other sources of income. The capacity of civil servants to support positive policy development was also threatened by the limited knowledge base and technical skills within the service. It is suggested that the Grindle and Thomas model tends to suggest that motivation is the single factor determining bureaucratic behaviour. Including the concept of capacity in the analysis, enables an assessment of the wider factors influencing bureaucratic behaviour.

3.5.4 *International Leverage*

Like "governments", "donors" are not homogenous entities. This sub-section identifies the key features which have characterised the donor response to the rehabilitation needs of the health sector. While not every donor-led programme is subject to each feature, most share at least one of the following characteristics: the desire to maximise control over design and implementation; preference for development over recurrent costs; complex administrative requirements; and an attempt to achieve universality of policy.

The absence of clear national health policy in 1986 meant that donors could neither conform with, nor fail to conform with government goals. As one informant put it " ..donors could do whatever they wanted in the immediate 'post'-conflict period. The government said 'yes' to EPI, 'yes' to the

rehabilitation of hospitals, 'yes' to the rehabilitation of Mulago, 'yes' to CDD. There was no attempt to redirect programmes because there was no central health policy" (NGO representative).

Policy in this period might be described as being in a state of free fall. Interestingly, major donors such as the World Bank, did not seek to impose conditions on aid flows to stabilise health policy in this period. "..[I]n the immediate 'post'-conflict period the government was in need of a great deal of money very quickly..there were vast needs for reconstruction of the physical infrastructure to provide basic services such as education and health. Under these conditions the Bank did not seek to demand difficult conditions, rather it sought to be extremely helpful" (World Bank official).

In the absence of a clear government policy, and in a situation of high aid dependency, donors were in a strong position to determine priorities and allocates funds. Accoridngly, Government was in a weak position to counter donor bids for programmes, both because the demand for any type of input was overwhelming and because of the limited bureaucratic capacity to regulate and coordinate aid.

Donors and implementing agencies thus sought niches for their own activities. For example, UNICEF implemented UNEPI, DANIDA continued to support essential drugs, while a host of other NGOs carved out projects across the country implementing a wide range of activities. While several donors and implementing agencies had representatives within the Ministry of Health during this period, for example UNICEF, SCF, AMREF, and the World Bank, they were largely concerned with the management of specific programmes rather than supporting the development of systemic policy (World Bank/GOU, 1992).

The proliferation of programmes uncoupled from any unifying policy framework enabled greater donor control over programme design and management. It also enabled donors to limit the risks associated with project implementation to carefully defined boundaries which conformed to their areas of expertise, while leaving out those services with which they felt less able to cope. For example, the control of malaria, a major cause of mortality and morbidity remained (and continues to remain) unaddressed (UNICEF officials). Interventions therefore tend to conform with areas of agency expertise rather than to health needs. This pattern of donor behaviour is not, of course, limited to 'post'-conflict situations. It is suggested, however, that the relative dominance of donors in de facto policy development, at least at the programme level, had a particularly distorting effect on the health system due to the weakness of government.

Donor preference for supporting development costs over recurrent costs also influenced choices of policy. One recent report has suggested that "..the main reason for this focus [on hospital rehabilitation] is that a country with a low income relies very much on donors for its rehabilitation and development programmes. ...[T]he rehabilitation of the health infrastructure...requires little money and gives quick and tangible results compared with other health problems" (Assiwme & Lule, 1993).

While it is true that significant donor resources have supported the costs of physical rehabilitation, this has been primarily through loans rather than grants. Because donor policy and funding generally favours primary health care, it has been argued that government has been forced to focus its efforts on the secondary and tertiary levels, limiting its involvement in primary health care (Lee et al, 1987). The major lending institutions and bilateral agencies have reinforced this trend by their own preference for capital spending. Grant-making agencies which are much more involved in primary health care, have become much more heavily implicated in sharing its recurrent cost burden.

Donor reluctance to support recurrent costs has had an effect on the development of the health system since 1986. In particular the practice of paying incentives and allowances to government staff has had a distorting effect on health worker behaviour, encouraging them to perform selected tasks (such as immunisation) to the detriment of their other duties (UNICEF official; NGO representative).

The bureaucratic procedures of international agencies have also affected policy design. The time-frames within which projects are designed imply important trade offs between competing policy

objectives such as completion of infrastructural rehabilitation and capacity building. Some donor agencies were unable to provide supplementary allowances to national ministry staff, despite the extremely low levels of government salaries (World Bank official). Rules did, however, provide for the employment of expatriate consultancies. Other donor representatives have questioned the appropriateness of their headquarters requirements in terms of setting minimum size of project grants. It was felt that in situations where there is limited national capacity and potential political instability there is a need for small, flexible grants, which can be disbursed at the district level through both non-governmental and governmental channels.. By re-packaging aid in smaller units, competitive tendering procedures could be bypassed, so reducing project complexity and costs, and facilitating greater community participation in rehabilitation efforts (Bilateral donor official).

Finally, donors have sought to implement programmes which conformed to universal policy goals which ignored the particular needs of countries emerging from a prolonged period of political instability. Their interventions tended to focus on generating measurable outputs, rather than supporting the underlying processes which support health systems and health development. The imposition of indicators of achievement, such as immunisation coverage rates, may fail to acknowledge the extent of the breakdown of health system, by achieving targets through highly vertical structures. In so doing, the pace and content of health policy development may be distorted, with inadequate attention being devoted to correcting systemic and structural inadequacies and inefficiencies. Similarly, it has been argued, that the conditions associated with structural adjustment have encouraged the government to let go of public sector expenditure, particularly PHC, and to pass responsibility for these activities into the private sector, including NGOs (NGO representative).

Table 5 provides a summary of the factors influencing policy choice.

3.6 Implementation of the Immediate 'post'-conflict Policy

Cleaves (1980) suggests that there are two basic conditions for successful policy implementation. Firstly, political and administrative actors need to mobilise power and resources to execute a policy design. Their ability to do so is contingent upon the influence and predilections of others in the political environment. Secondly, the specific content of a particular policy or programme can make it more or less difficult to implement. This section analyses the implementation process by identifying the absence/presence of the key resources required, and the "fit" of policy to the prevailing health needs and political-economic environment.

3.6.1 *Resource Requirements - Financial*

External aid for the health sector has been an increasingly important source of finance during the late 1980s and early 1990s. Aid was not fully mobilised until mid-1987 when the IMF-backed Rehabilitation Plan was published (Economist Intelligence Unit, 1992). In 1980 aid flows for health amounted to an estimated US$5 million or 4% of health expenditure;, by 1989/90 these had risen to US$35 million, and were predicted to rise to US$46 million in 1990 (Hill, 1991). The majority of this aid went to primary health services: in the years 87/88-89/90 83% of donor aid went to primary health care compared with 33% of government expenditures. Donor funding dominated both capital and recurrent health expenditures in 1989/90, with donors financing 66% of recurrent expenditures for PHC (Hill, 1991).

While donor support of the health sector remains high, Uganda overall is a relatively low recipient of international aid per capita. In 1991 the World Bank reported that Uganda's aid receipts were about 30% lower than the average aid flow to other SSA countries, despite being one of the largest IDA aid recipients; while bilateral assistance, though rising was only 40% of the SSA average (World Bank, 1991). It is unclear why Uganda remains a relatively low recipient of aid: possible explanations include the time it takes to re-establish contacts with donors after prolonged periods of interrupted government-donor relations; the perception that the country has relatively low absorptive capacity; and fear of potential political instability.

The low level of external resources has been compounded by the low tax base discussed earlier. This, combined with the low allocations to the health sector, has meant that absolute levels of health expenditure remain well below their 1970 levels (Table 2). These low levels of public finance available to the health sector have been manifest in the shortage of counterpart funding available to externally-funded projects. This in turn has been cited as a constraint to implementation by many donors and in several evaluations (World Bank official; MOFEP official; World Bank & GOU, 1992). By the late 1980s donors were increasingly accepting government's incapacity to raise its required contribution and a number were meeting 100% of project costs (World Bank & GOU, 1992; MOFEP official).

Corruption and embezzlement have also been blamed for limiting the finances available for rehabilitation. While no studies have been found which document the scale of corruption, interviews with national and international policy-makers, informal meetings with rural and urban communities and individuals, and press articles, revealed this as a major concern. Many people see corruption in Uganda as linked to the processes of criminalisation and illegalisation of the economy during the years of political turmoil. These processes are seen to extend from the small income-generating activities of public servants, including health workers, who exact informal fees for services in order to boost their meagre incomes, through to allegations of major fraud and profiteering. The increasing openness of the press, and the development of the RC system is serving to counter the perception that such activities were legitimate which several informants suggest developed during the 1970s and 1980s. The seriousness of these allegations in terms of rehabilitation became particularly clear in Luwero district, where the disappearance of very substantial sums of government and donor assistance prompted the appointment of a special Minister to monitor rehabilitation efforts.

One World Bank official suggested that external agencies underestimated the need to reduce the vulnerability of national staff to "external influences" by providing additional allowances to ensure that they could meet their basic needs. He argued that the lack of financial resources to do so, had undermined any attempts to build capacity within the public sector in that it reduced incentives to participate fully in development activities.

However, where agencies had provided additional allowances to staff, for example to attend training, this was also seen as presenting problems, creating a two-tier system of remuneration and threatening the sustainability of programmes as health workers became increasingly dependent on top up allowances (NGO representative).

3.6.2 *Availability of Resources - Political Support*

As noted in Section 3.5 health occupied a precarious position on the health agenda. During the implementation period, high level political support for vertical programmes such as EPI was sustained and served to mobilise local political leaders to participate in immunisation campaigns. One informant said that "..what was crucial to EPI's functioning was the political commitment which was shown by the President. EPI at that time [1986 onwards] was one of the most successful social development programmes in Uganda in terms of being able to see the result". One informant (expatriate academic) has suggested that these political pressures have tended to exacerbate the tendency to over-report and exaggerate the accomplishments of EPI.

However, successive poor bids for government funds by the MOH (Save the Children Fund, 1993; interview Health Planner), and the demands of other sectors, particularly defence, outweighed health in terms of gaining political priority.

The RC system presented a potentially valuable means of raising local level awareness regarding health issues and of increasing pressure for political attention at the national and district levels. However, the capacity of the RC system to transform itself from community bodies ostensibly concerned with security issues, as they had been in the early period, into those concerned with wider development issues, was limited by the NRM's own lack of clear vision as to the role of the RC system in health development (UNICEF official; Burkey, 1991). The process of politicisation as a means for health

mobilisation was further undermined according to some sources by the fact that the development of the RCs has been undertaken without any financial support from external agencies (Nalwanga-Sabina, 1991, NGO representative). While their lack of dependence on external sources of funds might serve to maintain their autonomy and so enhance their legitimacy, the fact that the RC system was typically unable to harness resources has meant that it is sometimes perceived as unable to meet community needs.

Donors and NGOs have tended to bypass district level resistance councils, and often use RC1s as a vehicle for implementation rather than acting in partnership with them (Welbourn, 1991; interviews, Soroti, Luwero). Thus, while RCs often interact with NGOs for health development, it is often as a passive partner and these activities typically fail to articulate with the public sector (NGO representative).

The development of community capacity to lobby for and maintain greater political support for the health sector in the years immediately following 1986 was also diminished by the fact that many communities lost their leaders either due to out-migration or death during periods of instability. One informant described the following scenario she had encountered among many communities "..communities are much more mobile now than they were in the past, many people, often those most in demand to provide leadership are leaving. This deprives communities of key human resources while donors are expecting greater inputs from them. For those remaining it is often found that one individual occupies many senior positions..this has implications for the autonomy and accountability of these respective organisations and for the amount of work people actually undertake" (Expatriate anthropologist).

Thus, the process of mobilising and maintaining political support for health development in this period was subject to the pressures and conflicts in the wider political arena. While the government was committed to rebuilding civil institutions, it worked with few resources and the NRM lacked a clear vision of the future function of the RC system in policy development and implementation (Burkey, 1991; Nalwanga-Sabina, 1990). It has been suggested that because donors tended to work outside of the RC system, the system's capacity to harness and utilise funds for community development within a political framework was limited.

3.6.3 *Availability of Resources - Managerial*

The effects of the brain drain, particularly on middle and senior level management were widely seen to have acted as a constraint to implementation of rehabilitation plans, particularly at district level. An evaluation of the First Health Project (World Bank & GOU, 1992) identifies many of the problems reported by other donors, citing poor financial management and limited skills in administrative and technical areas. It suggests that while considerable attention was paid to the interventions required for physical rehabilitation, an underestimation of the need to strengthen administrative and planning capacity meant that only limited functional rehabilitation had been achieved. It continued " A staff appraisal report of 1988 pointed to (several) main risks: poor implementational capacity of MOH in view of under-staffing, weak organisation and serious financial, managerial and administrative problems. At mid-term, and with the benefit of hindsight one can confirm the accuracy of these risks. In retrospect, while the emphasis on physical rehabilitation is understood, the need for planning and management support was underestimated" (World Bank & GOU, 1992).

One informant added "..staff welfare has never been addressed because donors fear that it is not sustainable, yet without increasing the motivation of staff rehabilitation will be impossible" (MOH official). This lack of attention to the pay and conditions of national staff was almost universally seen to have been a major constraint to the rehabilitation process, since it undermined morale and prevented staff from giving their full attention to the work at hand.

At the district level, these problems have been amplified in terms of health management and planning. District officials at both sites visited complained of the difficulties of recruiting appropriate staff, particularly for financial management and planning. The breakdown in the health information system,

and of staff motivation to reactivate it, has meant that the District Health Team has only limited information to work with, and limited training to utilise those data which exist. The ability of districts to plan the allocation of resources was seen to be further limited by the difficulty of coordinating and monitoring the activities of NGOs, many of whom failed to provide reports and accounts to the district administration.

The weakness of state structures was seen by NGOs as a constraint on their work: the Health Policy Review Commission reported that NGOs found it difficult to obtain clear government guidelines on issues such as training (Government of Uganda, 1987).

The management practices of NGOs themselves were also reported to present problems for donors supporting their work. Several informants reported difficulties in identifying "authentic" local NGOs, since many of them had been set up by businessmen and powerful local leaders, often disappearing once programme funds had been disbursed. The extent of the problem is hard to gauge; however, the increasing preference of donors to work through these organisations, rather than through government (Meyers, 1993), has undoubtedly contributed to the rapid increase in the numbers of NGOs in the country (350 are registered by the Prime Minister's Office) as groups seek to take advantage of substantial volumes of aid (NGO workers; international and national NGO workers; official, Office of the Prime Minister). Organisations such as the Community Based Health Care Association (CBHCA) have assisted greatly in encouraging the development of NGOs. This association, funded by UNICEF and chaired by an MOH representative, provides a means to coordinate NGOs at the district level through their local committees, chaired by the DMO. While the CBHCA has contributed to generating increased legitimacy of NGOs, a perusal of member organisations showed that many of them were linked to international agencies through funding or organisational ties. It is therefore unclear how far they have been able to address the problem of "briefcase" NGOs or encourage the development of authentic grassroots organisations which are genuinely representative of their communities.

3.6.4 *Availability of Resources - Technical*

The low quality of much of the original background data used to design rehabilitation programmes resulted in considerable overspending as work programmes had to be reformulated and budgets increased (World Bank official, MOH official). One informant highlighted the fact that rehabilitation plans tended to conform with the standards of the Bank, rather than with the resources available at the local level: the design of the programme and its complex contractual requirements tended to actually decrease the resources available for rehabilitation by demanding overly elaborate technical specifications.

Despite the relative improvement in drug supply through the EDMP, health workers in both districts visited reported that insufficient drugs remained an important constraint. Women and men interviewed suggested that until drug supply at the public health units improved, they preferred to use private practitioners and drug shops, when they could afford it. The EDMP insists that sufficient drugs are made available to health units, and it has been suggested that the high rate of pilferage by staff limits their availability. Achieving functional rehabilitation was therefore seen by community members as being contingent upon improving the drug supply, which in turn requires addressing the fundamental question of staff remuneration. Both communities and health workers emphasised that low salaries had a significant effect on the quality and accessibility of health centres, as health workers were often absent from their posts in search of alternative sources of income.

3.7 Outcomes

The key policy outcomes of the rehabilitation strategies implemented during the late 1980s may be considered as positive or negative, anticipated or unanticipated (Table 6).

3.7.1 Anticipated Positive Outcomes

Given the lack of consolidated statistics, it is difficult to be precise about the percentage of the health units which have been rehabilitated. The First Health Project will have achieved its targets of rehabilitating all the units it undertook to repair, and other initiatives such as that undertaken by UNDP and NGOs such as AMREF and MSF–Holland have achieved high completion rates. Interviews with the District Administration in Luwero reported that substantial repairs are still required at the more remote health posts in the district.

Immunisation coverage increased nationally, actual rates remain however fiercely contested. The impact of immunisation on infant mortality is also the subject of vigorous debate. This is both because it is likely that incomplete baseline data were available in 1986, and because of concerns that immunisation may not have affected absolute mortality rates due to increases in other causes of mortality and morbidity. In particular malaria and acute respiratory infections, which have not been addressed by the major vertical programmes, continue to claim the lives of a large number of children.

The EDMP was widely reported to be functioning relatively well, often providing the only source of drugs for health units. However, prescribing patterns and popular demand for medicines, particularly injectables, are seen to be the primary constraint to improving the efficiency of drug use, rather than simply the lack of regular flows of medicines to health units.

3.7.2 Unanticipated Positive Outcomes

Where communities have participated in the rehabilitation process it is also seen to have contributed to reconciliation. Describing a small rehabilitation programme in Gulu district, which has only recently achieved relative stability, one informant suggested that "up until now the people had no cause to work together, with the health centre it was make or break – either they joined together or they had no health centre"(Bilateral donor official). Physical rehabilitation was also linked with a wider process of social recovery. In districts such as West Nile, which had been largely depopulated as communities sought refuge in neighbouring Sudan, the rehabilitation of the physical infrastructure is said to have provided an incentive for populations to return to their homes (NGO representative). Given that few of the major rehabilitation programmes were either designed in theory to encourage community participation, or achieved it in practice (UNICEF & GOU, 1990), the relative importance of the former point is probably limited in the case of Uganda.

3.7.3 Anticipated Negative Outcomes

Donors responsible for the design of programmes in the immediate 'post'–conflict period seem to have been aware of the potential risks of their strategies. As the World Bank Evaluation of the First Health Project indicates, the initial design of the project allowed only limited attention to be placed on capacity building. While the project's failure to achieve this was thus a predicted outcome of its implementation, the evaluation suggests that the extent of the institutional collapse inherited in the 1986 period was underestimated at the initial appraisal stage.

With regard to programmes such as UNEPI and Essential Drugs, the perception of their verticality as "negative" is relative. Within any health system certain components, such as drug and vaccine supply, may be delivered more efficiently through vertical structures. In addition, although the verticality of EPI is acknowledged universally, it is seen by some commentators to be the means through which integrated and comprehensive health systems can be achieved (see, for example, Taylor & Jolly, 1988). Opponents of this view suggest that efficiency objectives need to be evaluated with respect to the whole health system, and that the verticality of programmes such as EPI actually threatens the development of the very structures required for integrated and participatory health systems (for example, see Rifkin & Walt, 1986; Gish, 1986). In this context, however, it is the relative dominance of the vertical programmes in health service delivery which is seen as a negative outcome of the rehabilitation process. UNEPI has run in parallel to other vertical programmes such as CDD and MCH, none of

Table 6: Summary of Policy Outcomes 1986-1990

	Positive	Negative
Anticipated	Physical rehabilitation of infrastructure Improvement in immunisation coverage Improvement in supply of essential drugs	Relative dominance of vertical form of health service provision Limited building of public health and policy-making capacity
Unanticipated	Physical rehabilitation as basis for sustained community participation Physical rehabilitation as basis for community reconciliation	Proliferation of programmes over systemic policy Distorting role of donors in policy formulation, undermining development of national capacity for policy analysis and implementation Unsustainable levels of recurrent costs Skews in salary system because of allowance schemes Reinforcement of urbanisation of provision High level of aid dependency Limited development of community institutions for health

which clearly link with the other. The lack of integration of these services at district and community levels has resulted in duplication and inefficienc. In addition, the allowance system has led to skews in health worker behaviour in favour of selected activities (District health workers, Soroti; UNICEF officials, NGO representative; Forsythe, 1991).

While the design of these programmes implied a high degree of verticality from the outset, their dominance of the health system and the difficulty of restructuring these initiatives meant that they presented a particular threat to the sustainability and comprehensiveness of health services. Forsythe (1991) has argued that in Uganda selective primary health care interventions cannot serve as the basis for the development of comprehensive and integrated health care, because the two systems serve different political and bureaucratic functions. According to Forsythe, the former conforms largely to the needs of national and international political and administrative systems to generate quantifiable targets and achievements within a relatively short period of time and do not challenge existing power relations, due to their dependence on medical professionals and imported technologies. By contrast, comprehensive PHC requires a redistribution of power in favour of the poor, but its outputs are less predictable, the process of empowering communities may generate conflict and instability, and outcomes from such programmes are not easily quantifiable.

3.7.4 Unanticipated Negative Outcomes

Programme design in the immediate 'post'-conflict period made important assumptions about the rate of economic recovery which have not been realised in practice. In particular, there was an expectation that the government would soon be able to take on the burden of recurrent costs associated with the rapid redevelopment of the infrastructure and the implementation of selected primary services. The extent of the government's inability to take over these responsibilities was not predicted, not least because calculations regarding the future recurrent cost implications of rehabilitation initiatives were never undertaken. This has meant that high levels of dependency on external aid, which have characterised the health sector in the immediate 'post'-conflict period, are likely to persist, and perhaps deepen as the full costs of initiatives undertaken at this time become more visible, services expand in the newly pacified north and east, and the population grows.

Aid dependence should not be conceived in purely economic terms. Donors and NGOs occupy powerful positions within the policy arena from where they have a strong direct and indirect influence over policy design. In the period 1986-1990, as the stake of donors in health increased, so has the number of technical advisers working in the MOH, and the level of their participation in the policy arena. Only limited training of MOH staff has been undertaken, particularly at the district level.

The rehabilitation programmes have also served to reinforce the urbanisation of service provision which characterised the pre-conflict health system and which was exacerbated by political instability. By concentrating a significant proportion of resources, particularly capital funds, on the rehabilitation of physical structures, improvements in access have been largely restricted to urban and rural trading centres (Assiwme & Lule, 1993).

Because of the focus on buildings and health hardware, inadequate attention was paid to the development of institutions which play a role in health development. Above, the limited effectiveness of the rehabilitation efforts on the development of capacity within key Ministries and at the district level was described. In addition, the failure to support the RC system at an early stage of its development represents an important opportunity cost, the implications of which extend beyond the health sector. One informant pointed out that the RCs play an important role in maintaining accountability at the local level. Financial support and genuine partnership with these committees could have realised savings by reducing possible corruption and support the wider processes of rebuilding civil society (NGO representative).

The process of "projectisation", where donors and NGOs operate within micro-environments, has reinforced the processes of fragmentation of the policy arena, initiated through nearly two decades of

political chaos and economic uncertainty. While these agencies undoubtedly felt the absence of clear central directives when planning their own initiatives, it would appear that few efforts were made by donors in this period both to coordinate their own activities and to establish fora for debate and dialogue between themselves and government.

3.8 Conclusion

Projects developed in the immediate 'post'-conflict period were designed at a time when the health system and the wider political and economic system within which it functioned were in a state of total collapse. The poor status of the health system was seen to merit an urgent response.

Many of the documents reviewed indicate that the projects formulated at this time were seen as emergency, first steps towards health development, and it was hoped that the initiatives implemented at this time – specifically physical rehabilitation, and the development of vertical programmes – would provide a platform from which a future comprehensive and integrated health system could be based.

There is now widespread consensus that these efforts may in fact have had a distorting effect on the health system, and that attempts to address the crisis of health financing and institutional development will have to confront a triple inheritance – an inappropriate health system developed prior to and immediately after independence, the effects of the war, and the effects of the rehabilitation efforts on the health system.

4.0 1990-1993: A CHANGING CONTEXT FOR REHABILITATION

4.1 Introduction

As a fragile peace has gradually been built in the northern and eastern districts, so plans for the rehabilitation of the health infrastructure there have been evolving, albeit at a slower pace. A question now facing health planners is whether there are lessons to be learned from the earlier period of rehabilitation in other areas of the country..

A crucial difference between 1986 and the present is that a proliferation of fora for health debate have developed in the intervening period, national political dialogue is more open/widespread, planners and health workers have been exposed to ideas and concepts from other countries within and outside of Africa, and there have been some improvements in the country's economic position. It is important to emphasise that the broader political–economic context within which rehabilitation of the North is currently being framed offers opportunities which were lacking in 1986.

This section provides a brief analysis of changes in health policy in this period, and builds upon this to highlight the ways in which lessons have been incorporated to a greater or lesser extent into rehabilitation policy in the North.

4.2 Towards Change & Reform: Features of the Policy Dialogue 1990-1993

Since 1990 two key policy documents have been formulated – the 10 Year National Health Plan in 1991 and the Three Year Health Plan in 1992.

The drafting of the 10 year health plan (Government of Uganda, 1991a) was a response to national and international pressure to formulate a clear health strategy to take the country into the next century. The resulting document built upon the earlier report of the Health Policy Review Commission. Like its predecessor, the 10 Year Plan presents a comprehensive overview of the actual and proposed health system. It did not, however, take account of the economic climate within which it would be implemented and so did not prioritise different interventions.

The draft budget attached to the document exceeded the best estimates of revenue in the period fourfold. Donor outcry prompted a return to issues raised in the World Bank funded study which had accurately described the nature and depth of the health crisis (Lee et al, 1987), but which had largely remained unaddressed in the intervening period (interview, MOH official: NGO representative).

The appointment of an expatriate technical adviser by the World Bank in 1991 saw a major review of health financing which culminated in a draft Three Year Health Plan in March 1992 (Government of Uganda, 1992b; 1993). The Plan sets out two major objectives: i) to consolidate existing services to achieve functional rehabilitation of existing units, and ii) to reorient health services to primary health care. The main body of the document is concerned with issues of health financing, and particularly with the question of the introduction of user charges.

The plan published in 1992 led to a renewed political discussion regarding the introduction of user charges. It is widely felt that the management of the political debate was clumsy (interviews, MOH officials; UNICEF officials), and limited efforts were made to sensitise national level politicians about the depth of the health crisis and the ways in which community financing would function. The National Resistance Council rejected the idea. However, at the local level many health management committees had already introduced the scheme and begun to levy fees. There was, therefore, a dichotomy between de facto and de jure policy.

In parallel with this development had been an ongoing dialogue within and between ministries and international agencies such as the WHO and UNICEF regarding the role of primary health care. This sought to realign the national health system away from its focus on curative care at secondary units

towards increasing the effectiveness and accessibility of basic curative and preventive health provision. It is clear from speaking to key informants that this debate has been vigorous, and is being sustained by related debates regarding health financing and decentralization.

Donors themselves also began to reevaluate the nature and function of their own work. There has been a widespread realisation that earlier initiatives failed to build sufficient national capacity, particularly for planning and management at the district level, and a number of discussion papers and debates within organisations such as UNICEF and the World Bank have been circulated (See, for example, Glennie, 1993a, 1993b; World Bank & GOU, 1992). Donors involved in vertical programming are also becoming more concerned with how to achieve a more integrated health system.

Changes in donor priorities internationally have also influenced the environment within which rehabilitation of the North is being planned. The World Bank, for example, was seen to have undergone a change of strategy during the late 1980s. One informant reported "The World Bank has changed direction regarding its involvement in health internationally. It now thinks about what inputs should be generally accessible, in other words it has changed its focus from secondary to primary provision. The physical infrastructure itself is not enough" (World Bank official). The depth of the change in approach is indicated by a World Bank document published in 1991, which contrasts strongly with its earlier programme objectives under the First Health Project. It argued "..that a pragmatic policy for the government would be to ensure initially that cost-effective primary and preventive services are provided to the maximum number of Ugandans, with a secondary objective of rehabilitating the hospitals necessary for referrals" (World Bank, 1991). While the report acknowledged that the government's role in primary service delivery might be one of regulation of non-government initiatives, there was a marked change in the Bank's approach to its role in health in the country and its view of where priorities should lie. This change of direction in World Bank strategy is reflected in the background documents prepared for the Second Health Project - The Community Health and AIDS project (CHAPS) (World Bank, 1993). The project objectives conform to government priorities laid out in the Three Year Health Plan (Government of Uganda, 1992;1993), in that a strong emphasis has been placed on consolidation of district health services and reorientation to PHC. In addition, the project proposes strengthening of central ministries, and components concerned with HIV/AIDS and population.

This change in Bank policy is particularly important since it has started to impose much greater conditionality on its aid to the social sector in the early 1990s. An informant reported that "It is only since 1991 that conditionalities have been imposed, for example regarding cost recovery [in the health sector]", although he adds "..Ugandans had no choice but to accept reform, the reality of the situation demanded it rather than donors exerting a strong pressure" (World Bank official).

Despite the apparent coyness of the major donors regarding the levels of conditionality they are now imposing on aid, indicators of its growing strength are increasingly visible. For example, DANIDA made it clear publicly that the extension of the EDMP would be conditional on the adoption of a National Policy on Essential Drugs. (A bill to this effect was rejected by the NRC in May 1993). Discussions with national and international health policy-makers also point to the increasing involvement of international technicians in health planning, and growing donor concern with the perceived failure of physical rehabilitation efforts, and their reluctance to follow a similar path in the North (MOH, MOFEP officials).

Thus pressure for reform and restructuring of the health services in Uganda have been the product both of internal and external pressures. Internally there has been an increasingly explicit recognition of the depth of the financing crisis, and wider political debates regarding decentralization have gained momentum. Externally, evaluations of the rehabilitation efforts have exposed the weaknesses of the prevailing strategies, while changes in international policy within different donors has been expressed in donor support internationally for decentralization (Mills et al, 1990), integration and primary health care.

4.3 Programme Response to the Rehabilitation Needs of the North

The health needs in the northern districts in the immediate 'post'-conflict period do not appear to differ substantially from those present earlier in the south. The North has always been relatively disadvantaged socially and economically, and it is likely that the *relative* impact of the war on health has been less great than in areas of the south and west. It is also likely, however, that the underlying structural inequalities between the two regions may mean that health recovery will be achieved at a slower pace in the North if substantial additional resources are not made available.

Programme development with respect to the North comprises both initiatives to expand national programmes and those specific to the region. The former type includes the efforts of UNICEF to increase immunisation coverage from its very low levels in the northern districts. In 1989 the national average for DPT3 coverage was 40% and was planned to rise to 80% by 1993 (UNICEF, 1989). In northern districts in 1992 DPT3 coverage was estimated at 11-26% in the northern districts, with the exception of East Moyo, which has not been directly affected by rebel activity and has reached levels of DPT coverage comparable with national targets (80%) (UNDP, 1992).

Background studies have expressed caution about the capacity of the existing health infrastructure to support the rapid expansion of national programmes (UNDP, 1992), and have therefore proposed that particular attention be placed upon developing district level planning, management and administrative capacity (ibid). It remains unclear, however, whether these efforts will be conducted as part of new national programmes to build capacity at the district level, or will attract additional resources given the particular difficulties in securing appropriately trained staff to work in the northern districts. The low level of the budget (US$500,000) for the five districts surveyed in the 1992 study, seems to indicate that even if special initiatives were to be mounted they are likely to be limited in scope.

The primary rehabilitation strategy of the MOH is also to incorporate the North into existing national policy and programmes rather than try to replicate the type of strategy initiated elsewhere in the country in the late 1980s, which concentrated on physical rehabilitation and vertical programming. So, for example, selected districts in the North, such as Soroti, were included in the district planning exercise conducted as part of the first phase of decentralization of health management in early 1993. This exercise involved MOH and MOLG staff going out into 13 districts and supporting district health teams in developing district plans (Ministry of Health officials).

Health has also been considered with the regional programme for rehabilitation developed by the Ministry of the North, in conjunction with the World Bank. A 1990 study, supported by the World Bank and implemented by the Ministry of Planning, identified five key sectors which required urgent rehabilitation assistance: infrastructure, education, health, water and demobilisation of soldiers (Brett & Ngategize, 1990). This broad brush analysis provided the basis for the formulation of NURP which took place in April the following year (Government of Uganda, 1991). This confirmed the focus of the earlier appraisal mission, and again, health was seen as a priority sector. The criteria applied to project selection were: a strong recovery focus of an emergency nature; high economic and social rate of return; modest institutional requirements in order to facilitate the rate of implementation and sustainability either through donor financing, cost recovery or through the government budget. The aim of the programme is both to rehabilitate the productive base and to promote more equitable distribution of wealth between the northern and southern regions.

The health component of the project had the following specific objectives: strengthening of the referral system; increasing the accessibility, coverage and utilization of health services; strengthening on-going programmes such as child survival, HIV prevention, and family health; and promoting a PHC strategy through community participation. The document proposed the structural rehabilitation of five hospitals and satellite health units; the re-equipment of these units; and community mobilisation to eradicate the major causes of morbidity and mortality and vector borne disease. Of the total budget of US$28.93

million the latter component constituted only US$3 million, while the bulk of the programme activities focused on rehabilitation and re-equipment of health units.

Subsequently, however, the World Bank has resisted undertaking a specific rehabilitation effort of the health sector in northern districts, dropping the health component of NURP because of their dissatisfaction with the First Health Project and their perception that the health component proposed in the initial NURP appraisal risked replicating earlier mistakes (official, Prime Minister's Office; World Bank official). Limited rehabilitation of the physical infrastructure in the North has therefore been included in CHAP (World Bank/GoU, 1993).

NGOs have been very important in rehabilitating the physical infrastructure in northern districts. MSF-Holland has repaired Soroti hospital and a number of health centres and sub-dispensaries (MSF-1992). The Italian NGOs AVSI and CUAAM have also been active in supporting rehabilitation in northern districts, as has SCF-UK (Brett & Ngategize, 1990). These rehabilitation efforts have often been linked to relief activities carried out by these agencies, but have not always been accompanied by commitments of long-term support.

4.4 Analysis of Policy Development for the Rehabilitation of the North

4.4.1 *Technical Analysis*

Analysis of the problems facing the North was hampered by insecurity. The northern regions had been largely excluded from national health surveys such as the Demographic and Health Survey conducted in 1989 (GOU/USAID, 1989). The weakness of the information base was similar to that seen in other areas of the country in 1986, and was thus unlikely to generate data which would provide the basis for detailed planning.

First efforts to appraise the situation coincided with a conference convened by International Alert and the Oslo Peace Research Institute (PRIO) in 1989. For the first time the extent of the health and development crisis in the North was discussed publicly and attracted international attention. Particular concern for the disruption to food production was noted in an annex prepared by Frances d'Souza (International Alert, 1989). It has been suggested that this conference and the accompanying report were extremely influential in generating donor support for conflict resolution and development in the North (NGO representative).

As government counter-insurgency strategy changed from one dependent on military action towards one relying on civil methods of conflict resolution, so the momentum for analysis of the rehabilitation needs increased.

The UN agencies working in Uganda also contributed to the process of analysis of health needs in the northern districts. In November 1992 an appraisal mission, led by UNICEF and UNDP, spent three weeks in 5 districts: the report highlighted the poor state of the physical infrastructure and the weak management and logistical support available to public health workers. It recommended that in addition to expanding coverage of existing UN programmes such as EPI, specific attention should be placed on re-establishing functional health units; building capacity of the health committees to strategically plan the health services; improving staff efficiency in managing health services and increasing the accessibility to health services (UNDP, 1992).

A characteristic of both the NURP and UN background studies is that neither were undertaken with a clear idea of the budgets available for work in the North. Both produced estimates of required expenditure far in excess of that which would later prove to be available both from donors and from government in terms of counterpart funding. For example, the initial figure for NURP was set at US$600 million. On seeing the figures, the World Bank asked for a reduction to US$213 million. When the government realised the extent of their expected counterpart commitments, the figure was reduced further to US$179 million.

Once again, only limited calculations of the recurrent cost implications of the capital expenditures entailed by both programmes appear to have been made.

Evaluation of earlier rehabilitation efforts appear to have made a more important contribution to the final choice of strategy adopted than the appraisal missions carried out (World Bank & GOU, 1992; UNICEF & GOU, 1991). While the appraisal missions proposed a similar emphasis on physical rehabilitation to those programmes carried out in other areas of the country during the late 1980s, this approach was rejected by donors and government.

4.4.2 *Political Support & Stability*

The political and economic context of rehabilitation in the North is also different from that which prevailed in the southern areas of the country in 1986. The northern districts were historically relatively underdeveloped as the colonial rulers had placed much greater emphasis on economic development in the more fertile and productive areas of the south. The colonial policy of divide and rule bestowed special legal privileges on the predominant Buganda in order to secure power nationally, and those from the southern areas came to have much greater access to education and employment within the colonial state than their northern neighbours. While the southern areas were the economic engine of the colonial state and provided national political leadership, northerners tended to constitute the "warrior class" since the army provided the only means for them to access influence and the economic advantages of state employment (Brett and Ngategize, 1990).

Obote, a Langi from the North, was elected in 1962, not because he could secure national support, but rather because the south itself could not achieve sufficient political consensus to support an alternative candidate. Amin too was a northerner, coming from West Nile. Both leaders had used ethnicity as a tool for the maintenance of power and had been responsible for oppression of ethnic groups other than their own. While both committed atrocities against different tribes in the North at different points during their rule, in the southern areas of the country there was particular distrust of northerners. The NRM's accession to power, led by Yoweri Museveni from the West of the country, was thus the first time that southerners saw a government which they felt represented their interests.

By contrast, northern groups saw the NRM's victory as a political defeat and there was widespread fear that the NRA would seek revenge for the atrocities committed by a largely northern army elsewhere in the country. The insurgency struggle mounted by different rebel groups in the North was thus both an expression of this fear and in certain districts of anger that the government had failed to protect them against the violent raids of the Karamojong.

The achievement of relative peace in the northern areas was both the result of a military victory by the NRM and of a broader process of pacification brought about through political efforts at conflict resolution effected through Presidential initiatives such as the Teso Commission, which sought to build a dialogue for peace and to promote economic and social development in the region.

Rehabilitation efforts in the North have thus been framed within a far more complex political context than that in the south. On the one hand there is a political necessity to demonstrate the government's commitment to peace, since the rebellion was threatening the political and economic integrity of the state. At another level, scepticism about the strategy was felt both within the North and within southern-dominated political and bureaucratic circles which remained suspicious of northern intentions.

The political division regarding policy to the North has been manifest in both pace and content of rehabilitation plans developed at the national level. A Minister for the North had been appointed in the late 1980s to oversee the process of pacification. The Minister, Hon. Betty Bigombe, is widely seen as having been very influential in keeping the North on the political agenda, and in achieving the process of reconciliation (Official, Prime Minister's Office).

At the district level political institutions have also remained weak. The development of the RC system in the North lagged behind that in the southern areas of the country as RC members were frequently targeted by rebels and the system was perceived as the arm of a government which lacked widespread legitimacy in the North (UNICEF official; Soroti interviews).

The nett result of these contradictory political trends is difficult to determine. What is striking however, is the slow pace of the discussion: initial talks regarding NURP took place in 1988 (Official, Prime Minister's Office), by mid-1993 implementation was only just starting. On-going insecurity during this period was an important factor limiting government room for manoeuvre, and the willingness of donors to provide assistance to a region which was highly volatile. Interviews with informants in Soroti and in Kampala and appraisals prepared in this period indicate, however, that there were substantial areas of the North which were relatively peaceful and secure and within these there were opportunities for rehabilitation and development. The potential of such a strategy was clearly recognised by agencies such as the Teso Commission which sought to link the processes of pacification with those of development. The Commission and others have stressed the need for an incremental approach to rehabilitation which builds upon an accurate analysis of political conditions to identify "pockets" of areas where rehabilitation can start (Brett and Ngategize, 1990). Careful consideration regarding the type of input is also required: large, highly visible projects may become targets for rebel activity and may therefore serve to attract violence. Smaller, more discrete inputs can provide a valuable psychological and material support to communities recently recovering from conflict. This is confirmed by the experience of ODA, where a small, discretionary grant through the embassy provided for the rehabilitation of health units. Implemented on a participatory basis by a local NGO, the rehabilitation programme acted as a vehicle for community reconciliation, an experience echoed by that of MSF-Holland in Soroti district (interview ODA official; MSF-Holland, 1992).

Overall it is difficult to assess how far the slow pace of rehabilitation has been a function of political inertia, and possible sectarianism, and how far it is a reflection of the paucity of resources available nationally. The potential costs of rehabilitation in the North are likely to be extremely high, particularly if the aim of these interventions is not simply to restore the North to its pre-conflict levels of development, but rather to achieve greater equality between northern and southern districts.

District level capacity for lobbying for increased resources and a swifter pace of intervention seems to have been limited by the reluctance within northern communities to participate in the RC system and their limited representation within senior levels of government. This failure to galvanise high levels of political support led one informant to ask "why is it that although the district has just emerged from an insurgence the centre is not willing to provide additional resources for rehabilitation? Is it because of sectarianism or for other reasons?" (member, District Administration, Soroti).

4.4.3 *Bureaucratic Motivation*

Bureaucratic attitudes towards the reconstruction efforts in the North are difficult to gauge at the central level, particularly for an outsider. While several ministry staff have travelled to the region as part of World Bank teams and in district planning exercises, private conversation with others has indicated a fear of going to the northern districts because of insecurity, which has perhaps limited widespread recognition of the gravity of the situation facing many northern communities. The extent to which this, and perhaps ethnic prejudice might affect both the planning and implementation of the programmes is again a difficult and sensitive question to answer.
One informant indicated that the bureaucracy has been able to resist "..the great political pressure to rush into the North and to do something both from donors and from local politicians" (MOH official). If this is the case then bureaucrats might have provided a buffer against political pressure for a quick fix as they strengthened their own capacity to influence and guide policy formulation.

Through the establishment of an office for the Rehabilitation of the North a mechanism has been put in place to monitor different ministries implementation of NURP activities. Given that the health

component of NURP was dropped, the capacity of this office to influence MOH interventions might be limited.

4.4.4 *International Leverage*

Among many donors the perception was that it was they, rather than government, who were spearheading rehabilitation efforts in the North. Donors, other than the World Bank, reported that they had not been actively lobbied by government to provide additional resources to the North, rather they had initiated this (UNICEF officials; bilateral donor representative; NGO representative). As discussed above, the PRIO conference in 1989 was seen as influential in mobilising initial international attention regarding the situation in the war-affected areas of the North, and international awareness about conditions in these areas has been confirmed during official missions to the region (UNICEF representatives; bilateral donor representative; UNDP representative).

International concern regarding the war arose not simply because of humanitarian motivations, but also because of the impact of the conflict on Uganda's political and economic development. Military expenditure was a significant drain on the public purse and threatened adjustment measures. During the 1990s, growing international attention to the conditions of good governance has also played a part in increasing donor participation in debates regarding the political context within which their programmes are being implemented. As a representative of a bilateral aid agency put it "although Uganda has now turned the corner economically, it is not out of the woods politically". Among some country representatives of donor organisations it was suggested that there is a need to plan strategically for regional development in Uganda if a sustainable political system is to develop. This type of analysis may run counter to policy at headquarters which tends to promote sectoral rather than regional initiatives, and there may thus be a conflict between the analysis presented by local level officials and official policy (Bilateral donor representative).

The NURP is the exception to this rule, and one informant has suggested that its regional interventionist strategy, with a focus on production, runs counter to the laissez-faire policies advocated nationally (NGO representative). While the programme may not conform fully to World Bank economic policy, it might be seen to fulfil its wider political objectives as one informant suggested: "The World Bank knew that the government would use the programme as a political tool. In some countries such as Kenya at the moment the Bank would not support such measures, but they did so in Uganda because people within the Bank who knew the country supported Museveni" (World Bank official). The fact that health was not included in donor attempts to reinforce national support for the government, perhaps explains why strategies to address the most visible and politically obvious manifestation of the war-related crisis in the health sector – the destruction of the health infrastructure, has not occurred in the North.

Despite widespread donor interest in the rehabilitation effort in the North, it has not been matched with substantial inflows of aid. The period of rehabilitation has coincided with international recession and most donor organizations are preparing for cuts in real levels of expenditure. There is little scope for donors to reallocate resources away from their existing programmes in those areas where they have been working since 1986, and they are in a poor position to seek additional resources to expand or introduce new programmes into the northern regions (Bilateral donor representative; UNICEF representative).

It might therefore be argued that donors have been important in mobilising national political support for rehabilitation of the North; however, this pressure is not seen to have translated into specific strategies for rehabilitation of the health sector. Donors' role in *health* policy formulation in the North has not been influenced by political concerns, as it has been in other sectors. Rather their policy preferences have been shaped by their experience of health sector rehabilitation in other areas of the country since 1986. Donors have thus operated within two distinct spheres of influence. At the political level they have contributed to encouraging the resolution of the conflict and in mobilising limited resources for rehabilitation of production: this has been linked to macro-economic concerns among donors regarding the impact of the war on adjustment and the potentially destabilising effect of persistent

underdevelopment in the North. Specific debates regarding health sector rehabilitation have fallen outside of this rubric, and have been primarily influenced by donor and government experience of rehabilitation in other areas of the country since 1986. Donor responses have tended to focus on integrating the North with national health restructuring, without mobilising high levels of resources to rehabilitate the health infrastructure in that area.

4.4.5 *Summary of Factors influencing Rehabilitation strategies in the North*

Rehabilitation strategies employed in the war-affected northern regions differ from those adopted in areas at peace since 1986. It would appear that these differences cannot be accounted for by real differences in the situation facing the two regions in the immediate 'post'-conflict period, although the socio-political and economic context did certainly differ. The inheritance of war in both areas saw an increase in health needs accompanied by a collapse of the health system. There is no specific plan for the rehabilitation of the health system in the northern regions, rather an incremental approach has been adopted which seeks to incorporate the war-affected districts into national health policies which favour building district level capacity and the reorientation of the health system towards PHC.

The difference in response can be accounted for by a number of mutually reinforcing factors. Evaluations of earlier rehabilitation efforts were important in alerting donors and bureaucrats to the risks of focusing on physical rehabilitation as a primary policy objective. While pacification of the North was seen as an important national political objective, there appears to be a lack of political consensus regarding the urgency of social rehabilitation of the northern regions as a means of sustaining the peace. This lack of consensus is reflected by the fact that while political institutions responsible for rehabilitation efforts are highly visible, they lack significant public resources for their operation. This is perhaps not surprising given the current pressures on the public purse and the country's history of sectarian politics. Those within government campaigning for greater attention to the development needs of the North have been supported by international pressure which has highlighted the need for improvements in social and economic development in the region. However, while international leverage has been important in keeping the development needs of the North on the political agenda, it has not been accompanied by substantial aid flows.

4.5 Implementation of the Rehabilitation Programme

The slow pace of rehabilitation efforts in the North means that it is difficult to report on policy outcomes. However, risks associated with its implementation can be identified, based on interviews with national and district level officials and communities in Soroti. What follows is therefore a tentative effort to identify some of the potential weakness of the strategy which might constrain implementation. Once again, these are grouped around issues concerning the availability of financial, political, managerial and technical resources. It is important to stress that what follows is based on a short visit to Soroti, and should not necessarily be seen as representative of the variety of districts in the North and North-east.

4.5.1 **Financial Resource Availability**

At the central level, the government continues to suffer from an acute scarcity of resources due to the persistently low levels of revenue. While the potential for significant reallocation of resources towards social development is implied both in recent government policy statements which describe its retreat from involvement in the productive sector (GOU, 1992) towards the provision of public goods such as health, and the savings arising from demobilisation and demilitarization, both of these reforms will take time to bear fruit.

The northern regions have historically been relatively economically disadvantaged, a position exacerbated by nearly seven years of war. Substantial inputs are therefore required if the gaps between North and South are to be bridged. It is important to stress that the achievement of relative peace in the region also carries a cost in that during the periods of insurgency government allocations

to local administrations in these areas were effectively reduced as district capacity to expend resources diminished.

Thus, while providing basic allocations remains difficult, government capacity to make additional allocations to the health sector in the North to accelerate the pace of health development in the region and so bring it into line with other regions remains limited. The national scarcity of economic resources will also have an effect on the ability of the government to provide counterpart funding for rehabilitation efforts and to sustain the increase in utilization of public health services which has occurred as populations return to their homes and relief agencies withdraw their support for emergency medical services.

In addition, the absence of data and mechanisms to promote equitable allocations of resources between districts remains a constraint to health development throughout the country.

The capacity to raise revenue at the local level also appears limited. One sub-county chief in Soroti described how he had to redesign the formula used to assess taxable income: the existing guidelines were seen to be redundant in a situation where community members had lost their key assets, cattle, and whose subsequent capacity to farm had been reduced. War-induced poverty has thus had a considerable effect on the capacity of local administrations to raise taxation to support rehabilitation and has compounded the social and economic inequalities which existed prior to 1986. A report prepared in 1990 pointed out that districts in the North are typically unable to raise more than Ushs 35-50 million compared with more than UShs 600 million by wealthy districts like Mukono (Brett & Ngategize, 1990). Figures from Soroti district support these findings; major improvements in the proportion of tax collection during the period 1989-1991, absolute levels of income remain low at Ush 109 million in 1991/92. Of this only Ushs 22 million was allocated to public health. The draft District Plan 1993-1995 (Soroti District Administration, 1993) acknowledges that little increase in local revenue is likely.

The Soroti district health plan indicates that the gap in income from local and central government and planned expenditure in the period 1993-1995 is to be partly bridged through the introduction of community financing. This is predicted to exceed combined local and central government expenditure approximately seven fold. In order to meet these targets fee levels are to be set between 300-650 shillings for consultations at dispensaries, health centres and hospitals (Soroti District Administration, 1993). At the time of this research fees were set at Ushs 100. While the study did not attempt to undertake detailed investigations of the impact of community financing on utilisation, health workers and community members were asked what their perceptions of the impact of the scheme had been on access to health services. While these informants revealed a high level of understanding of the aims of community financing, and expressed a willingness to pay for services, they reported that the low availability of cash income in the area had resulted in falls in utilization of 25-75%. One indicator of the depth of cash scarcity were reports from a mission that it too was experiencing a crisis of recurrent financing as the number of outpatients and inpatients for acute health problems was falling, reportedly because of inability to pay, at a time when numbers of patients suffering from chronic diseases such as TB and AIDS (exempted from charges) was increasing. No surveys of elasticity of demand for health services had been conducted as part of the preparation of the District Health Plan, and the potential effects of a 300% increase in user charges on both access and subsequently on revenue can only be guessed at, particularly given the other demands on cash income for rehabilitation of shelter and agricultural production in the immediate 'post'-conflict period.

Donors are expected to fund approximately 70% of the district health plan in Soroti. It is not clear whether this level of support is based upon actual donor commitments or provides a basis for soliciting donor funds. In addition, there is no discussion within the plan of the institutional mechanisms which will be used to channel these funds, nor of the capacity of the local administration to absorb such substantial inflows of aid. Several factors might suggest that these expectations of major increases in donor financing might be overly ambitious. The district is widely perceived to be insecure, and donors are therefore cautious of risking substantial investment there. Donors themselves are also facing

budgetary cuts and are therefore seeking to consolidate, rather than expand, their commitments in Uganda.

4.5.2 *Political Support*

As discussed above the political environment within which rehabilitation is being implemented remains complex. There is a certain irony in the fact that the strategy currently in place lacks the visibility that might be required to ensure political objectives of rehabilitation, yet it is in the northern districts, more than those in the south, where the government needs to gain increased legitimacy. As one informant put it "..in the North the government doesn't have the credibility to mobilise communities, yet the major health strategy under the CHAP is for community mobilisation. In the south they did have sufficient credibility for community action, and in the North the need for rehabilitation of the physical infrastructure is greater than it was in the south. In some senses it could be said that as far as the North is concerned the government rehabilitation strategies have been the wrong way round" (NGO representative).

In Soroti district it has been an NGO (MSF–Holland) rather than the government which has been responsible for physical rehabilitation. An evaluation of its activities noted both the potential contribution to health that rehabilitation had made and that it had served an important function in terms of rebuilding community institutions in a context of social dislocation (MSF–Holland, 1992). While the government could not have undertaken the rehabilitation programme initiated by MSF in the late 1980s and early 1990s, because it lacked the neutrality accorded to an NGO in a situation which was still insecure, the failure of the government to come in with visible programmes was perceived by some people in the district as an indication of the NRM's lack of concern for development in the region.

4.5.3 *Managerial Resource Availability*

The limited capacity at the district level for planning, management and administration is widely reported in appraisal missions (see, for example, UNDP, 1992; Brett & Ngategize, 1990). There is difficulty in recruiting senior staff to work in the region because of the perception that it remains unstable. The breakdown in local administrative capacity, linked to the out–migration of senior staff during the war, potentially threatens absorptive capacity at the local level. In all these respects, the lack of availability of managerial resources is similar to that experienced earlier in the south.

4.5.4 *Technical Resource Availability*

An important consideration when trying to assess the likely difficulties of project implementation is whether the base from which policies designed at the centre conform to the conditions found in northern districts in this immediate 'post'–conflict period. In particular, issues of possible concern are the skills base of health workers, the capacity of local administrations to finance drugs to supplement essential drugs kits provided through EDMP, and the viability of the community financing scheme in the context of extreme cash scarcity. In addition, the poor state of repair of the physical infrastructure may constitute a constraint to efficient functioning.

4.6 Conclusion

The poor health status of the population in districts such as Soroti is perceived as a constraint to the wider processes of economic rehabilitation (Sub–county chief, Soroti DA). The revival of immunisation services combined with a gradual return of the displaced to their homes has seen some improvement in the incidence of communicable diseases such as TB and measles. However, the rate at which peace has been secured has not been matched by the pace of efforts to improve access to health services – those improvements which have been seen have largely been due to the activities of NGOs, who could work within the precarious security situation of the early 1990s. While it is encouraging that some of the lessons of earlier rehabilitation efforts appear to have been learned, there is a danger that as national health debates move from those concerned with rehabilitation to development, the particular

requirements of district health systems entering the immediate 'post'-conflict period will be ignored. There is also a risk that these lessons become "carved in stone" and fail to contribute to a planning approach of sufficient flexibility to take the differential needs and socio-political conditions of different areas into account.

While in other areas of the country the private sector, including NGOs has been able to plug the gaps in service provision, this remains relatively underdeveloped in the North because of cash shortages and the limited historical involvement of NGOs in the region. Because the health component of the major rehabilitation programme for the North was dropped, and the Second Health Project is unlikely to become operational until 1995, there is a risk that the rate of health recovery in the region will be much slower than that found elsewhere in the country after 1986. It is clearly desirable that the northern region should be integrated into national efforts to reform and restructure the health sector: not to do so would result in a divided system. However, it will be important that the particular health needs of the population and of the health system are taken into account in the planning and implementation of these efforts. The acute scarcity of resources at district and household level, the weakness of political and administrative structures and the fact that the region has not benefitted equally from earlier national health programmes, means that additional resources and flexible planning measures will be required.

5.0 IMPLICATIONS & ISSUES

5.1 Introduction

Berke et al (1993), writing about recovery after natural disasters suggest that "..the recovery period offers an opportunity to facilitate economic, social and physical development long after the disaster." For countries recovering from prolonged periods of war there is also a peculiar development opportunity, which is both political and financial. The political opportunity is inherent in the historical moment accompanying the end of conflict when new governments strive to create new political and social orders, are receptive to demands for policy change, and often wish to demonstrate their commitment to the community. The economic opportunity accompanying periods of transition – from war to peace, from totalitarianism to democracy – may include the revival of production and substantial inflows of external aid to support capital investment and structural adjustment.

While the opportunity is real, its extent is difficult to gauge when put side by side with the constraints and obstacles to development inherited in the 'post'-conflict period. These have been described in earlier sections, and include: widespread morbidity and disability, economic devastation, political instability, changes in psychological attitudes to risk, technical weakness of project design and the demands and dominance of the international aid system.

Any attempt to evaluate Uganda's experience of 'post'-conflict rehabilitation of the health sector must therefore be placed within the wider question of how to frame expectations for development in these unstable and vulnerable situations. Given that the processes of reform themselves generate instability and rely upon a minimum level of resources – financial, managerial, political and bureaucratic for their implementation, and that these resources are typically limited in societies in transition, it is perhaps unrealistic to expect radical change in the immediate 'post'-conflict period. However, as described in previous sections, the long-term costs of failing to adjust the health system in the immediate 'post'-conflict period are such that they cannot be ignored, and if the opportunities for substantial change are not seized early, the structural weaknesses and failures of the past will continue to imperil the future.

This concluding section explores these contradictory pressures on health policy formation, planning and implementation. The discussion pivots on the idea that the two apparently contradictory characteristics of the 'post'-conflict situation in Uganda – the need for, but incapacity to achieve, reform – might be reconciled if the issues of pace and content of health policy formation and implementation are also addressed. The question of pace in 'post'-conflict situations is particularly crucial given the overriding perception of different actors that the need for a policy response is urgent.

As health policy is typically synonymous with health services policy, and health services are likely to have only a limited impact on improving health status, there are risks that the *urgency* of the task might be overemphasised at the cost of more appropriate policy making. While the provision of basic, health-supporting goods such as shelter, food and water can be seen to have an immediate impact on health status, and therefore can be considered urgent needs in the immediate 'post'-conflict period, the suggestion that hospital rehabilitation is urgent is surely open to question (World Bank, 1992). Given that hospitals are likely to have only a limited impact on health status, that implementation of hospital rehabilitation is likely to be logistically complex and costly, and that it is likely to have significant implications for recurrent costs, there are important arguments in favour of slowing any overhasty physical rehabilitation programmes. Achieving this in practice will require avoiding the adoption of emergency style approaches to development problems.

This question of the pace of the response to the 'post'-conflict health crisis is central to understanding why, in the Uganda case, apparently so little attention was paid to the risks inherent in the rehabilitation strategy employed in 1986.

The combination of this tendency of government ministries, politicians and donors to rush in, with the fact that they were operating in the absence of a clear national policy framework, has meant that policy

has failed to keep pace with plans and programmes, thus threatening the coherence, sustainability and efficiency of the health system. While at one level the urgency of the "policy" response might appear misplaced, even irrational on strict public health grounds, it is essentially grounded in human nature and good intentions to do something, anything to "make it all better". As Foltz (1992) has written with regard to post-conflict rehabilitation strategies in Chad, it would indeed be a hard hearted politician or donor who refused to address the more visible legacies of war in the shape of a shattered health infrastructure. The point is therefore how to harness this motivation within a framework which meet the wider structural conditions for sustainable and equitable health development.

This section therefore explores these two related themes: the first concerning the viability of adopting a reformist approach to rehabilitation, the second examining the pace at which restructuring and redefinition of the health sector might be achieved. The chapter concludes with a list of potential areas for future research which the discussion raises, and a summary of key findings.

5.2 Key Issues

5.2.1 *Developing Alternative Policy Scenarios*

A striking feature of the Uganda case study is that the analysis of the problem was circumscribed by the prevailing attitudes of politicians, bureaucrats, health professionals, and, to a lesser extent, donors regarding what the health system should look like. The overriding aim of the majority of politicians and civil servants was to reconstruct the health infrastructure to its pre-conflict levels. Donors too, sought to re-establish what had been lost, to revitalise previously existing programmes. Dodge (1986) has suggested that within Uganda attitudes to health policy were frozen in time, back in the 1970s.

Yet the intervening 16 years had seen radical new paradigms of health development emerging from Alma Ata, and issues regarding health financing and organization had become prominent on the international health agenda (Rifkin & Walt, 1986; World Bank, 1987; Mills et al, 1990). These debates and subsequent attempts to realise them in practice in many countries, provided a potential basis to develop alterative strategies for rehabilitation in Uganda.

While donors did contribute interventions which had not formed part of the pre-conflict health system, such as EPI, these became appendages to the previously existing health policy, rather than integrated with a public policy designed to deliver comprehensive primary health care.

As discussed previously, the Health Policy Review Commission's report did not provide a solid platform for systemic policy development because it did not take account of the resources available for its implementation, nor did it confront the inbuilt inequalities and inefficiencies in the pre-conflict health system. The weakness of national research institutions meant that a potential source of alternative information and debate was extremely limited. The bureaucratic and political pressures which were seen to generate an agenda primarily concerned with structural reconstruction, were not countered by other pressures, national or international, to develop alternative possible scenarios for health sector development.

The fora for debate which did exist were limited and drew heavily upon those with the largest stake in reproducing the health system inherited at independence. Nationally, fora for debate regarding health development had broken down, and health had never occupied a place on political agendas. Health remained depoliticised, despite the fact that it was sometimes used by politicians for political gain. Meeting the more visible aspects of the health crisis, such as the deteriorating physical infrastructure could bring political rewards. However, the lack of a history of radical debate on health issues at the community level meant that constituents in rural areas were unlikely to press politicians for an increase in the appropriateness and equity of health provision.

Internationally, donors provided few pressures to create a coherent systemic policy framework and health strategy, choosing to avoid placing conditions on their aid, and to act within their own policy

arenas. The concept of "conditionality" does not necessarily imply punitive sanctions, rather it is suggested that positive conditions and support mechanisms can be put in place which offer incentives to different actors to participate in policy dialogue and debate. In the case of Uganda there was little incentive for either politicians or bureaucrats to use the opportunity of peace as a moment for more radical reappraisal of policy objectives. Bureaucrats tended to see their role in rehabilitation as implementing political prescriptions, not to alert the executive to the potential hazards of any one strategy. For their part, politicians carried their own assumptions about what a health system should look like and were under pressure from politically influential groups to see it rebuilt in its pre-conflict form.

It is suggested that the opportunity for a reappraisal of policy might have been realised if fora for policy debate had been broader, involving community based health groups, women's organisations, and other community-based political and social movements, and if there had been an incentive for politicians and bureaucrats to participate in it more vigorously. A number of mechanisms and techniques might be used to generate such a dialogue. The Resistance Council system provided a unique institutional framework which might have been used to facilitate communication between the centre and district level. Decentralization of health policy debates and responsiveness to local needs is particularly crucial in a situation where different areas of the country had been differentially affected by war, poverty and epidemics such as HIV/AIDS.

The work of the Review Commission was supported by international donors: UNICEF and WHO provided financial and technical assistance to the Commission. However, other donors did not play an active role in its work, nor did they use the opportunity of a national health debate to present their concerns and priorities. For example, the Commission does not seem to have been aware that throughout 1987 the World Bank was negotiating with the MOH for the First Health Project (interview, member HPRC). While donors lamented the absence of a clear policy framework, they do not seem to have taken clear steps to facilitate a more appropriate and action-oriented policy dialogue. In particular, no emphasis was placed on creating an environment in which more fundamental changes to potential policy content could be considered.

Donors themselves also lacked a mechanism to coordinate their own activities in the immediate 'post'-conflict period and did not have agreed objectives for their respective inputs. It might be argued that donors too lacked an incentive to ensure the coherence of the policy framework, since the lack of government control over the policy arena allowed them to occupy their preferred programme niches.

Yet if alternative fora had existed, which enabled greater communication between national and international health policy-makers, district and central officials the possibility that alternative scenarios for health development would have been considered is likely to have been enhanced. The structure of policy debates in Uganda prohibited central issues from appearing on the policy agenda until rehabilitation strategies had been implemented and their negative effects on the health system had become increasingly visible.

An alternative approach might have seen items for debate agreed between central, district and donor organisations, requiring an exchange of data from the variety of programmes and baseline surveys conducted within Uganda. Donors might have encouraged the inclusion of topics of international concern within the national context. Innovative methods such as the Delphi technique could be used to facilitate discussion and to achieve consensus on priority concerns and potential strategies for their resolution. Save the Children Fund (UK) has used one participatory method to develop its PHC programme in Kumi. The agency brought together officials from the MOH and MOLG, members of the RC system and district administration to discuss the development of the project. The participants gathered at a workshop and a situation analysis of health status and health provision in the district acted as a key resource. The working method, Ziel Orientierte Project Plannung, enabled participants to build upon the situation analysis to identify and tackle the underlying causes of problems, through the development of a problem tree. Alternative strategies to resolve each problem were evaluated according to a set of criteria identified by participants as critical to the programme's success – including,

sustainability and community participation. Resources required for each programme component were identified, management structures discussed and a summary of the project design presented in the form of a logical framework (SCF, 1991).

Issue 1 – Facilitating broad–based policy discussions

Issue: The lack of a clear health policy framework was a major obstacle to the development of a sustainable health system and to the effective use of health resources, particularly from international agencies.

Options: Supporting the creation of broad based policy fora increases the likelihood that key issues will be included on the policy agenda from the start. Such fora would underpin the process of stimulating and facilitating debate regarding the role of the health sector and the key policies which are required for the sector to play its part in health promotion. Initiating and sustaining debate may require identifying the different incentives required by civil servants, bureaucrats, professionals and international actors to participate in the consultation process. Such incentives might include increasing understanding about popular expectations of political parties, donor conditionality and ensuring that the financial and technical needs of civil servants engaged in policy analysis are met. Creation of such fora will therefore require financial and technical resources, which international agencies are in a strong position to provide. It will also mean ensuring that sufficient time is made available for the policy debates to take place, policy options to be considered, consensus achieved, priorities determined and implementation mechanisms agreed. The creation of solid policy fora should not be equated with parallel issues of conditionality, rather the primary aim of such fora should be to encourage the development of national capacity for policy analysis, and to facilitate the exchange of ideas between interested parties.

Policy fora should encourage debate between the wide range of stake–holders and interested parties in the health sector. These include communities, health workers, professionals, private sector providers, pharmaceutical and other health–related industries, bureaucrats, politicians, client groups (etc), local and international NGOs, bilateral and multilateral aid organisations etc.

In order to avoid a situation where policy development is "all talk and no action", it will be important to adopt a needs based approach to policy development, and to ensure that interventions are prioritised according to criteria agreed by the different actors involved in policy design and implementation.

5.2.2 *Data Priorities*

In 1986 there was a severe scarcity of data of all types, even the size of national product was unknown (Government of Uganda, 1987). Some efforts were made by donors to improve the information base as they sought to design and implement programmes; however, exchange of information between government and external agencies was limited, and in any case, national capacity to collate or utilise such data was limited.

A characteristic of policy debates in 1986/7 was that there was minimal participation of district level officials and community members in the process of needs assessment. Information collected was largely designed to meet the needs of policy–makers, particularly donors, rather than that of potential consumers of health services. Not only does this potentially threaten the complementarity between perceived needs and actual programmes implemented, it also ignores the knowledge held informally within communities.

Techniques of rapid participatory appraisal offer a means to inform national policy-making and district level planning. While it is clear that such techniques could not be used nationally in a context of insecurity and poor communications, careful selection of samples within selected districts could generate information regarding health needs, community strategies in place to meet these needs and gaps in provision. Collection of such data need take no longer than studies conducted by agencies such as the World Bank to appraise rehabilitation needs, and might contribute both to improving the accuracy of data – qualitative and quantitative, and feed back into policy formation. The sample areas could also act as sentinel sites to monitor the progress of implementation.

Issue 2 – Types and sources of Data

Issue: Routine systems of data collection break down in situations of extreme stress. Yet the availability of basic information regarding health needs and financial and human resources, will be vital to the development of a coherent national health plan. It is unlikely that quantitative data alone will provide the means to assess community health needs and to prioritise them. Important potential sources of information at the community level are often ignored.

Options: Developing innovative and participatory mechanisms for data collection, including assessment of needs can contribute valuable information, and a potential means of monitoring implementation. Greater use of qualitative data collection techniques should enhance the appropriateness of data and contribute to achieving greater efficiency of scarce research resources. A wide variety of data may be useful. These include information on deaths, morbidity and disability and their distribution in the community, the location and operational function of health services personnel and an assessment of their level of morale and commitment to the health sector, the nature, form and extent of private sector involvement in health, the level of other health-related inputs such as water and sanitation services, the degree of geographic and socio-demographic inequity present, financial resource availability (both capital and recurrent), information regarding the activities of bilateral and multilateral agencies, local and international NGOs etc.

5.2.3 Planning for Contraction

Cumper (1993) points out that bureaucratic and political institutions tend to be ill-equipped to cope with situations where the resource base is contracting. He argues that the conventional planning approaches used to respond to reductions in public sector budgets tend to conform to the demands of civil service hierarchies and political expedience rather than to the underlying problems facing the system. Cumper argues that "the planner or administrator looking forward could plausibly tell themselves that both the underlying problem and its health service manifestation were in the course of being solved..indeed they might be in political hot water if they were seen to be sceptical about recovery". Hence the incremental approach to planning tends to dominate even when resources are declining. He suggests that planning for contraction is typically associated with protecting expenditures perceived as central to maintaining institutions (such as permanent staff salaries) rather than according to criteria of need or effectiveness. A particular threat to sustainability exists in 'post'-conflict situations, where reducing capital expenditure, a frequent strategy in resource constrained environments, is unlikely to be available. Indeed the likelihood of rapid increases in capital expenditure is more likely to be true, given pressure on government and by donors to be seen to be rebuilding national infrastructure.

The underlying assumption in the plans formulated in Uganda during the immediate 'post'-conflict period was that economic recovery would be substantial, swift and sufficient to sustain a rebuilt health system. 'Post'-conflict situations, like other transitionary situations, conform to those described by Etzioni (1973) as occasions likely to demand a comprehensive reappraisal of policy directions which can then serve as the basis for incremental decisions.

Cumper (1993) notes the paucity of policy instruments to effect rational and equitable planning in situations of contraction. While macro-economic tools such as devaluation are well known, no similar set of measures are available to social planners and policy makers. The provision of welfare safety nets by donors such as UNICEF and the World Bank can serve to sustain the illusion of expansion in an economically contracting state.

Breaking the cycle will depend upon developing approaches to planning which prioritise health needs and interventions in an environment which encourages reappraisal of fundamental policy goals and in which forecasts of the likely availability of recurrent funds are made. Achieving this would rely upon securing national level political and bureaucratic support and donor participation. Again, the issue of incentives to these different actors is of vital importance.

Issue 3 – Planning for Contraction

Issue: Rehabilitation of the health sector typically takes place amid acute scarcity of resources. Health budgets are likely to be lower than in the pre-conflict era, while the demand for capital investment is likely to be high. Economic recovery is likely to be constrained by structural features inherited in the 'post'-conflict era.

Options: The precondition to resolving this problem will be explicit recognition and acknowledgement of a financing crisis. Developing approaches to planning which explicitly recognise the limitations to incremental expansion of health budgets is crucial to developing a sustainable health system. Identifying the obstacles to changing planning practice – educational, political, economic – within political and bureaucratic circles will also be important.

5.2.4 Planning in unstable situations

Throughout this report it has been stressed that the achievement of peace is typically a relative and incremental process. Uganda is no exception in this respect – while 75% of the country was relatively stable and secure after 1986, large regions continued to suffer from intense violence. The process of pacification in the north and north eastern regions of the country initially relied exclusively upon military strategies, but was later changed to dual approach which maintained an armed response while nurturing a process of conflict resolution through development. Early appraisals for the NURP project encouraged such an approach, suggesting that significant pockets of peace existed within the region where development activities could be started, even while insecurity persisted in surrounding areas. It is also important to stress that different areas are likely to be more or less accessible to different people and organisations: for example, NGOs, including missions, are more likely to be able to penetrate rebel-held areas and secure their interventions than government staff.

Initiating rehabilitation prior to the total cessation of conflict either nationally or regionally is therefore likely to be constrained by on-going insecurity. The rehabilitation process may itself influence the nature of the conflict: inflows of aid may help to win hearts and minds and reduce sources of conflict, if they are seen to reduce existing inequalities and signify reconciliation and the end of discrimination. In other words, developmental inputs may serve to increase the legitimacy of one party to the conflict. Conversely, visible inputs may serve to attract violence if opposing forces seek to control more resources, perhaps through looting and/or aiming to undermine their opponent's attempts to gain legitimacy through development.

Timing and content of rehabilitation inputs is therefore crucial, as is the choice of implementing institutions. Resolution of these dilemmas will depend upon detailed understanding of the nature of conflicts, building dialogue between different armed groups, and ensuring that communities themselves are involved in discussions regarding alternative inputs and are encouraged to voice their perception of risk. Again, achieving this process in practice is likely to be subject to enormous difficulties. However, NGOs, such as MSF-Holland who rehabilitated a number of health units throughout Soroti

district, have built upon their knowledge of micro-level political and security conditions, worked with communities and across government-rebel lines to achieve their objectives. Some units were subsequently looted, and one prominent RC member, who had facilitated community involvement in rehabilitation was killed by rebels, perhaps because of his role in the programme. However, the actual and potential risks were acknowledged and the losses accepted (MSF-Holland, 1991). Flexibility of programme design will be crucial to enable appropriate measures to be taken in areas differentially exposed to the risk of violence. This flexibility must be seen both in the context of local conditions and be built into national policy strategies to ensure that initiatives conform to national policy goals of equity, efficiency and effectiveness. This will be particularly important to facilitate the integration of health units in conflict-affected areas into the national health system once greater peace has been secured.

Issue 4: Planning in Unstable Situations

Issue: The achievement of peace tends to be relative rather than absolute in 'post'-conflict situations. A major dilemma for communities, government and donors will be when rehabilitation should start, and understanding the political implications of (not) undertaking rehabilitation at a particular time.

Options: Planning rehabilitation measures in areas where instability persists will require identifying the risks and potentials of working in these areas. A high degree of flexibility in programme design and the full involvement of communities in the assessment of risk will help ensure appropriate development activity given the constraints operating locally. Rehabilitation programmes may form a basis of conflict resolution if dialogue between the opposing parties is encouraged, resources are protected and community participation facilitated.

5.2.5 Balancing the psychological value of physical rehabilitation with wider demands for comprehensive, integrated rehabilitation

Box 4 compares two approaches to rehabilitation, funded by the ODA. The initiative in Gulu, like those of MSF-Holland in Soroti, sought to rehabilitate the basic physical health infrastructure. SCF's programme in Kumi aims to implement a district wide programme of integrated and comprehensive Primary Health Care through building institutional capacity and promoting community participation.

These two projects lie at different ends of the rehabilitation spectrum and represent a microcosm of the dilemmas faced by health planners in 'post'-conflict situations [9]. The Gulu projects illustrates the psychological and social value of rapid interventions designed to achieve a visible input in a deprived environment. The Kumi project demonstrates the considerable complexity, financial resources and time required to plan for, let alone implement, a rehabilitation strategy which promotes longer term development.

The key question is whether elements of both approaches can be integrated into a phased approach which acknowledges the political, social and psychological value of rapidly restoring or creating the basic infrastructure for health service delivery, while planning for sustainability and encouraging community and district involvement in health. It is clear that there are no easy answers to this critical dilemma, which is perhaps the most unique feature of 'post'-conflict situations. Resolving the dilemma will, however, require that it be *acknowledged* at an early stage of rehabilitation planning by all the different actors – national and international, central and district. In addition, it is important to note that the relative psychological and political value of the restoration of the health infrastructure at the

[9] Material for this section was gained from interviews and document reviews. Visits to the respective projects sites was not feasible.

community level is not always easy to gauge. If, as is likely, other inputs such as improved access to clean water, or credit, are perceived as more valuable to communities than the rehabilitation of the health unit, these interventions might provide a platform for debate within communities regarding rehabilitation of the health system.

A process of consultation, sustained and supported by the available local institutions, such as the RC system in Uganda, will be central to achieving a balanced trade–off between the political and psychological value of rapid interventions and those which support developmental rehabilitation.

Box 4: Potentials and constraints of physical and comprehensive rehabilitation strategies

Project 1:
British Embassy Project - Rehabilitation of Physical Health Units, Gulu District, £50,000

Gulu district is in the north of Uganda and has been subject to widespread rebel activity since 1986. By 1992 relative peace had been secured, but the region remained potential volatile. This project was funded under a discretionary grant by the British embassy in Kampala. Implemented by World Vision Uganda – a national branch of an international NGO and a local contractor, work started in August 1992. By April 1993 two health centres and five dispensaries had been rehabilitated and one new dispensary had been built.

Strengths of the project:

* Small, flexible grant with limited donor administrative requirements, in particular the small size of the grant averted the need to employ international consultants for appraisal and technical assistance

* Low profile of project reduced likelihood that it would be targeted by rebels

* Implementation through NGO and local contractor kept price low

* NGO facilitated community involvement in management and implementation of the project

* Demonstrated feasibility of working in unstable situation

* Encouraged the return of displaced people from urban to rural areas, broader psychological value of restoration of health infrastructure

* Rapid pace of implementation

Potential weaknesses:

* Sustainable? Assumption that public health system will be able to support recurrent costs and provide adequate inputs to ensure minimum quality of service required to ensure adequate levels of utilization

* Meeting priority needs? Unclear how this intervention conforms with district health plan, needs identified by communities

* Limited contribution to building knowledge among rural poor and health workers

Project 2: Save the Children Fund UK - Comprehensive & Integrated Primary Health Care Project, Kumi District, £3 million

Like Soroti and Gulu districts, Kumi is only now achieving relative peace. SCF was involved in the provision of relief to displaced people in the district, particularly those living in government resettlement camps in early 1990. When the camp populations returned to their homes later that year it was decided to "follow" people out of the camps and to provide long-term support to them for health development.

A situation analysis was prepared in February 1991 which identified the main health problems, described the functioning of the health system in the district and identified the key constraints to its successful functioning. This analysis provided the basis for a participatory planning exercise which included a wide range of participants from district and central health and political agencies. The project is broad-based and includes aspects as diverse as strengthening management skills and logistical support, increasing resource availability for health (including the rehabilitation of the health infrastructure), and increasing the knowledge base within communities and among health professionals. Plans for implementation were still being finalised in May 1993. The British Overseas Development Administration is providing 100% funding for the project.

Strengths of the Project

* Participatory process of project design likely to increase ownership of interventions, particularly among district health team and key local administrators and politicians

* Explicit planning for sustainability by acknowledging linkages between different facets of the health system, emphasis on improving knowledge base.

* Likely to facilitate functional rehabilitation at health units because it addresses organisational and wider resource issues

* Commitment to integration of PHC services reduces risk of exclusive emphasis on curative care

* Significant resources available – more likely to achieve health impact

* Incremental, phased approach to implementation as capacity is built

Potential Weaknesses

* Slow pace of implementation because of participatory approach and complexity of donor requirements – are health needs being met in the interim period

* High dependence on bilateral donor inputs creates potentially complex administrative arrangements

* Risk that slow pace of implementation will limit resources available in long term – difficulty of holding budgets over from year to year

* Replicable? Implications for equity at national level? Will improving the functional capacity of one areas lead to imbalances between areas as they compete for resources?

Issue 5: Balancing the "Quick Fix" with strategic planning for sustainability

Issue: Rehabilitation strategies can be characterised in two broad categories: those which are designed primarily to restore the physical infrastructure and those which are planned to achieve sustainable, integrated development through the rehabilitation process. While the former strategy delivers rapid, visible results which serve valuable psychological, social and political functions, they are potentially difficult to sustain and may not provide the most appropriate basis for health development. Planning for integrated and comprehensive rehabilitation may overcome these potential weaknesses, but the slow pace of implementation may not meet political demands for rapid action, and the complexity of such programmes means that they carry a high degree of risk.

Options: Achieving a balanced approach between these two strategies will require an explicit recognition of the risks inherent in both, and will demand planning methods which phase implementation over a prolonged period of time. Ensuring the political acceptability of such an approach will demand consultation and education at both community level and among key decision-makers. As described above, this in turn will require the establishment of widespread debate around policy issues, involving all the key stakeholders, and ensuring that interventions meet the priority needs of communities identified through participatory methods of appraisal and action-oriented research.

It will be crucial to assess the potential long-term impact of "interim" measures on the future sustainability of the health system, and to assess the extent to which these measures do in fact constitute a basis for integrated and comprehensive health care packages. Rapid rehabilitation of the physical infrastructure and the development of vertical programmes do not necessarily conform to these objectives.

5.2.6 Roles & Responsibilities of Donors

The role of donors in policy formulation in 'post'-conflict situations cannot be underemphasised. The high level of donor support for capital and recurrent health expenditures means that they have considerable leverage in determining what can and should be implemented. It might also be argued that they have a concomitant high level of responsibility for the successes and weaknesses of policy.

In the immediate 'post'-conflict period donors do not appear to have placed any overall conditions on the use of aid to the health sector. Those conditions employed were placed on individual programmes, and did not relate to general policy directions. In the absence of clear government policy each donor worked within their defined area of interest, with seemingly little reference to the impact of these interventions on the health system as a whole. Once again, the perception of donors seems to have been that the urgency of the task precluded detailed planning and coordination, particularly regarding long term-sustainability.

Donors did not seek to control or stabilise the free fall of policy either by establishing a consortium through which those agencies supporting the health sector could plan and prioritise their aid allocations, nor by actively ensuring that a coherent national health policy was in place prior to finalising aid commitments. Indeed, at one level it is somewhat paradoxical that donors should choose to exert conditionality on their aid only at a time when national capacity for policy analysis, planning and management was developing in the early 1990s, when they were reluctant to do so in the immediate 'post'-conflict period to resist internal pressures for strategies which focused on physical rehabilitation. It might be argued that donors are likely to adopt a wait and see approach to imposing conditions and developing policy dialogue. However, it might be suggested that it is exactly when there is a systemic failure of public policies that donors have a particular responsibility to ensure that policy dialogue is encouraged. Without this, donor interventions are likely to contribute to the fragmentation of the health

system, rather than to effect the necessary consolidation of health programmes required in a climate of extreme scarcity of resources. While donors were able to exert significant power and influence within the confines of their own particular programmes, the lack of donor coordination meant that the sum of this influence did not contribute to the development of national health policy guidelines by government.

As the full extent of policy failure in the immediate 'post'-conflict period has become evident, there is an increasing sense that donors are blaming government for the inappropriateness of the rehabilitation strategy. Yet, donors themselves had much greater international experience to draw on, particularly regarding the reorientation of health systems in favour of PHC and of the health financing crisis facing many countries in Africa. They also had much greater financial and technical resources available for programme appraisal.

While the sense of urgency in part explains donor behaviour in the immediate 'post'-conflict period, it does not provide a full explanation of why donors were so willing to support a series of programmes which were likely to have such negative implications for the efficiency, equity and effectiveness of the health sector. The very openness of policy in 1986 meant that each donor could implement programmes of its choice according to policy paradigms operating internationally. So, for example, the World Bank was concerned with the construction of secondary health facilities, and UNICEF with a series of vertical programmes. The overwhelming need for *any type of programme* translated into *every type of programme* being implemented without clear priorities being set.

Important questions therefore emerge as to both the roles and responsibilities of major donor institutions in the context of a weakened state. In Uganda, it might be argued that the mistakes made in the immediate 'post'-conflict period are now being learned, resulting in part in the internal momentum for reform. In other words, that the hands off approach of donors to public policy may have encouraged greater national ownership of policy in more recent years. Two important considerations limit the usefulness of such an argument. Firstly, aid expenditures in the immediate 'post'-conflict period carry opportunity and actual costs which themselves influence the long-term sustainability of the health sector. Most obvious of these are the long-term recurrent cost implications of substantial capital expenditures and the difficulties in translating vertical programmes into integrated comprehensive services. Secondly, it suggests that within the MOH and MOLG sufficient capacity has been built to enable greater financial and technical autonomy in the policy-making sphere. It is clear that considerable progress has been made in strengthening the quality of national health policy debate, indicated by public debates regarding the efficacy of certain donor programmes and increasing government demands that donors conform to national policy on such matters as decentralization. However, the extent of aid dependency in the health sector means that policy remains highly vulnerable to donor opinion. Indeed, it might be argued that as donor resources decrease in the context of international recession, dependence is exacerbated as donor budgets contract and competition for donor resources intensifies. In addition, donor penetration of the national policy-making spheres has increased rather than diminished over time.

The demands of sustainability and respect for national sovereignty suggest that the imposition of strong, punitive conditions on a top-down basis is likely to be of limited value. Rather, it is proposed that donors can play an important role in facilitating the processes of policy debate, gathering data, identifying needs and reestablishing services.

While the creation of donor consortia and the imposition of strong conditionality on aid flows is no guarantee of appropriate policy development, it is suggested they may at least enable a more integrated analysis of the problems facing the health sector, and have encouraged donors to realise the extent of their involvement in sustaining the health system at an earlier period. Such mechanisms need not be seen as threatening national sovereignty if they are used as a basis for a dialogue between government and donors rather than as a punitive instrument of control.

Coordinating mechanisms can also be encouraged at the district level by NGOs working within the health sector as a means of working with the District Health Team to identify the respective roles of

public and private sectors, to ensure equity and to facilitate institutional learning on both sides. The establishment of such working relationships would also provide for a process of learning which could be disseminated upwards and outwards as key policy dilemmas facing each side could be discussed with national level staff.

Issue 6 – Roles & Responsibilities of Donors

Issue: 'Post'–conflict situations are characterised by political instability and weak bureaucratic institutions. Donors were the primary source of funds for rehabilitation in Uganda and also implemented many programmes outside of government institutions. The high degree of national dependency on aid carries with it an international responsibility to ensure the sustainability and equity of health interventions. Donor behaviour tended to exacerbate rather than alleviate the problems associated with the breakdown in health policy, particularly because their own programmes were not coordinated within a clear policy framework.

Options: Potential mechanisms to ensure greater effectiveness of the donor response include the formation of donor consortia and the use of positive conditionality; in other word rewarding appropriate decision making. In order to ensure that such mechanisms encourage rather than block the development of national policy making capacity, it is important that they are used to create dialogue between donors and government rather than as a punitive tool.

5.2.7 Choice of Implementing Institutions

Brett & Ngategize (1990) writing about rehabilitation in the north and north–east of Uganda have suggested that identifying implementing institutions should precede the choice of programmes. They explain this initially baffling suggestion by pointing to the extreme weakness of all types of civil institutions in the war–ravaged areas. They argue that since successful implementation will be contingent upon the smooth functioning of institutions, priority should be given to supporting those which are relatively intact in the first instance. They suggest that conducting an institutional audit will reveal which type of institution is most suited to implementing different facets of rehabilitation programmes. This analysis conforms to that given by Mader (1987, quoted in Berke et al 1993) who suggests that the chances of successful implementation increase when "..planning measures fit disaster needs and opportunities and there is local reliance on internal capabilities rather than external resources". Yet institutional choice does not seem to have been a matter of debate in the period post–1986. Particularly striking is the lack of discussion of the potentials and limitations of the private sector, both for–profit and not–for profit, including NGOs.

Donor choice of implementing institutions is particularly crucial in the context of the weakened state since it is likely to have important implications for both sustainability and equity. Again, issues of pace are likely to have a significant impact on determining policy choice: swift implementation of programmes is unlikely to complement a second policy objective of rebuilding national capacity. Donor policy within Uganda and internationally in the immediate 'post'–conflict period tended to favour working outside government institutions and maximising the role of the private sector, particularly NGOs. In Mozambique, such policy has been criticised as undermining government authority and capacity, as well as being wasteful of resources through the establishment of duplicate, parallel facilities (Hanlon, 1990).

The periods of instability had been accompanied by a process of privatization of health provision (Whyte, 1990). Self–management, the most extreme form of privatization, was paralleled by an increase in the importance of NGOs and missions as health service providers (Scheyer & Dunlop, 1985). The private sector was thus more resilient to change and indeed thrived under it. Whyte (1990) argues that the effect of these changes was for a democratization of health as health service providers became increasingly deinstitutionalised and responsibility for health was passed from health professionals to

community members. Such an interpretation suggests that there might be considerable scope for increasing the effectiveness of self-management through health education programmes designed to promote the rational use of drugs, and to improve the training of drug shop owners and attendants.

While Whyte's analysis is pragmatic it perhaps risks underestimating the negative public health effects of self-management and the effects of excessive privatization on equity. This is especially important in the absence of government capacity to monitor and regulate the activities of private providers. It points, however, to the need to develop regulatory guidelines and the means to enforce them. While the former were provided in the Health Policy Review Commission, District officials in Luwero indicated the difficulty in enforcing them.

Regulating NGOs has also proved difficult in Uganda. The phenomenon of "brief-case" NGOs, established to take advantage of donor preference for non-governmental agencies in the late 1980s has been reported as a problem, and raises concerns about claims that NGOs are more representative of local communities. However, strong NGOs, such as The AIDS Support Organisation (TASO) have emerged since 1986 which have achieved national coverage and have proved highly effective in reaching the community level. De Coninck (1992) reports on the increasing use of NGOs by donors to channel official development assistance; a trend which he explains as a form of political insurance in an uncertain climate. The most formalised collaborative venture between official donors and NGOs is the PAPSCA initiative. NGOs also feature in Lome IV and World Bank-funded proposals for rehabilitation in the north under NURP (ibid; Government of Uganda/World Bank, 1992).

While the work of many NGOs, particularly the missions, is highly regarded by government and international health workers, there is the risk that an over-reliance on them as implementing agents may result in a high rate of displacement of key staff from the public to the private sector, fragmentation of policy guidelines and inequalities in the distribution of health resources in favour of the more accessible districts (de Coninck, 1992; NGO representative). In addition, NGOs are frequently more dependent on external aid than public services often drawing all of their income from governmental donors or northern NGOs. The claim that NGO activities tend to be more sustainable than those in the public sector is thus dubious in these circumstances.

The RC system appears to have been the most under-utilized institution in health development since 1986. This is both because of the lack of clear political objectives regarding their development described above, and because of apparent donor reluctance to support their development financially. It is significant that debates regarding the role of community participation have coincided with debates regarding strategies to address the crisis in health financing. It might be argued that the recognition of the RC system as a mechanism for community management of health is long overdue, and the failure to support planning and administrative capacity at an earlier stage might carry an opportunity cost which may threaten the implementation of community financing schemes.

Importantly, the RC system provides strong links between national and district institutions through the RCVs. The place of districts at the forefront of health development is a comparatively recent innovation deriving from the NRM's strong commitment to decentralization and growing international interest in the role of districts in health service delivery (Mills et al, 1990). The hazards of overemphasising the district as a primary implementing institution are well documented, and include the potential threat to equity if district financial and human resources differ by region, the potential fragmentation of planning as district health teams are empowered to make more decisions, and the difficulty in ensuring the equitable distribution of external aid within a decentralized system (Mills et al, 1990; Kalumba & Freund, 1989; MOLG offical).

Current debates within Uganda regarding decentralization have identified these difficulties and there is a concern that the pace of decentralization might overtake existing district capacity. This dilemma would have been even sharper in the immediate post-conflict period, when the RC system remained fragile and district resources considerably diminished. However, similar problems existed at the central level in 1986. Given the great differences between districts in their health needs, and the potential for

local political and bureaucratic involvement in health planning and management through the RC structure, this system represented an important, but under-utilised institution for health recovery.

Again, district capacity to implement policy can only be assessed with respect to the policy goals they are expected to achieve. The presence of strong, but modest, national policy objectives, would have enabled districts to plan flexibly to meet their particular needs and to implement them. As it was, they, like the central administration, were required to be all things to all people without sufficient resources to meet basic health needs.

Issue 7 - Choice of Implementing Institutions

Issue: In the immediate 'post'-conflict period, public institutions at the national and district level were extremely weak. By contrast, the role of the private sector had increased during the periods of instability. The relative strength of private institutions, including NGOs, can be seen as an important resource for health development in the immediate 'post'-conflict period. Indeed, donors placed great emphasis on supporting the development of the private sector, particularly national NGOs. Yet, there are concerns that without regulation and mechanisms to ensure the equitable distribution of these providers, significant support to the private sector may serve to undermine policy objectives regarding accessibility, sustainability and equity.

Options: Auditing the available implementing institutions will be an important part of the policy design process. Uncritical support of the private sector, including NGOs, without adequate mechanisms for regulation and monitoring are likely to undermine efficiency and equity goals, and the development of government capacity. Support of district administrations at an early period of rehabilitation may enable greater flexibility of programme design, but the capacity of the district to achieve policy objectives will be contingent upon the presence of a clear policy framework and sufficient resource availability.

5.2.8 *Content of Rehabilitation Programmes*

It has been suggested that the health burden in 'post'-conflict situations is likely to be particularly heavy. This is due both to the long-term indirect consequences of conflict which promote widespread poverty and increase exposure to communicable diseases such as TB and HIV, and to the direct effects of injury, rape and extreme psycho-social stress. Interviews with communities in Luwero and Soroti suggest that these particular health problems have not been given sufficient attention by public health services. In particular, poor psychological health was seen as a widespread problem by many women and men who were interviewed, and was perceived as a constraint to the wider processes of economic and social recovery. It is difficult to clearly identify cause and effect in these situations: is it poor mental health which results in low productivity and social well-being, or is it rather the difficulties of trying to rebuild social and economic structures in the absence of loved ones which contributes to continued psychological strain?

Traditional healers provide an important source of support for those suffering from poor psychological health, and are seen as able to explain the cause of suffering better than health workers trained in the western tradition. However, public sector health workers reported that they were treating a wide range of stress related health problems, but lacked appropriate training and medication to deal with these problems adequately. Similarly, inadequate services exist at the community level for rehabilitation of the disabled.

Understanding the psycho-social impact of war is important if programmes are to be designed which recognise the particular constraints to community involvement in rehabilitation and development. Those suffering from poor mental health are less likely to participate in community initiatives but may be

among the most disadvantaged if they are unable to effect wider economic recovery. The long-term effects of conflict on community structures are likely to be profound if neighbour distrusts neighbour, where significant changes in gender relations have occurred and key members of the community are lost through violence. Explicit recognition of the social context of rehabilitation and individuals' capacity to participate in community activities and health development will be vital.

Interventions to improve the psycho-social status of communities will therefore rely upon improving the capacity of health workers to respond to individual needs, and recognising the wider constraints to health development inherent in post-conflict situations. The development of community based rehabilitation programmes which meet the needs of disabled people will also be crucial.

Issue 8: Responding to the particular health needs of conflict-affected communities

Issue: Conflict-affected communities are likely to bear a heavy burden of ill-health related to the long-term indirect and direct effects of conflict. Public health workers generally fail to identify the additional burden which conflict imposes on community health status.

Options: Mitigating these effects will be contingent upon achieving broader economic and social recovery, but will also rely upon improving the training and capacity of health workers to provide particular interventions. These would include improving the diagnosis of stress-related health problems to avoid inappropriate prescription practices, basic counselling skills, provision of basic aids to disabled people, and enhancing systems for controlling communicable diseases.

5.3 Issues for Further Research

This pilot study aimed to identify the key issues and dilemmas facing health policy-makers and planners in a country recovering from prolonged political instability. It also provided the basis to plan for an expanded study of health policy in 'post'-conflict situations elsewhere in Africa. As reported in the introduction, the limited time for the study and the flexibility of the research design prohibited detailed investigation of all issues. The following is therefore an attempt to identify issues which would merit further research.

5.3.1 *Investigation of health needs in 'post'-conflict situations*

Informants at district level suggest that ill-health is a major constraint to wider economic and social recovery: in particular, poor psychological health was seen to be a threat to social functioning. The degree to which war-related stress constitutes an obstacle to health and development generally deserves much wider attention. While a considerable literature has developed which is concerned with the psychological impact of war, its effect on functioning has not been closely investigated. Little is known of the effects of widespread social stress on patterns of health service utilization and the potential for mental health to be included in PHC services. Equally, the extent of disability and the control of communicable disease, linked to the direct and indirect effects of war, remain under-researched. Again, developing appropriate rehabilitation strategies will be contingent upon gaining an improved understanding of the prevalence and types of disability and their impact on social and economic life.

An improved understanding of the depth and particularity of health risks in post-conflict recovery would enable more accurate targeting of health resources, and perhaps encourage greater allocation of resources to the health sector in situations where there is strong competition between sectors for government and donor assistance.

5.3.2 *Methods of Facilitating Debate & Formulation of National Health Policy*

It has been suggested that a major weakness of rehabilitation efforts conducted in Uganda was that they were implemented outside a coherent policy framework. The capacity for national policy debates had been greatly reduced by conflict because of the brain drain, fear, lack of participation in international health policy dialogue and the lack of incentives to generate alternative policy scenarios.

If the processes of fragmentation and duplication which tend to characterise health systems in the intra-conflict period are to be reversed, it will be important to establish a clear policy framework at an early stage of the rehabilitation process. Achieving a sustainable national policy debate will require identifying the factors which promote or constrain the adoption of different policy scenarios. Creating the conditions for such a policy debate might include the presence of particular types of health information, provision of incentives to politicians and bureaucrats to engage in a debate regarding the need for fundamental reform and the willingness of donors to coordinate their activities. Experimentation with different techniques for achieving such a dialogue would be of relevance both in post-conflict situations and in other situations of political transition.

5.3.3 *Mechanisms for Donor Coordination & the Use of Conditionality*

Related, but distinct issues are whether the presence of donor consortia and the use of conditionality as a means of exerting leverage over the national policy arena would necessarily increase the effectiveness of the national and international policy response. Exploration of the potentials and dangers inherent in such strategies would be informative.

5.3.4 *Planning for Contraction*

Tools which facilitate the prioritisation of health needs and alternative interventions are urgently required if equity of resource allocation is to be maintained.

5.3.5 *Potential and Constraints of Rapid Participatory Appraisal for Policy and Planning*

Again, further investigation of the possible uses of RPA is required as a method of increasing information available at national and district level for policy and planning purposes.

5.3.6 *Public/Private Mix*

Privatization of health provision is likely to be an important feature of the health system in 'post'-conflict situations. Further investigation of the potentials and constraints of different types of private provision would enable the identification of the key roles of the public sector to be clarified. In particular, mechanisms of strengthening the ability of the state to monitor and regulate the private sector warrants attention.

5.4 Conclusions

Asked whether he felt there were any lessons to be learned from the rehabilitation process carried out in Uganda in the mid-1980s, one informant answered "Yes, to be modest in your objectives and to ensure that priorities are set according to needs". This brief statement captures the essence of what was absent in the immediate post-conflict period in Uganda - clarity and brevity of objectives and mechanisms to prioritise interventions on the basis of need.

In addition, rehabilitation was seen as a prelude to development, not a part of it: by contrast we can envisage an approach which might be described as developmental rehabilitation. Such an approach of identifying health needs, identifying existing community capacity to meet these needs and prioritising the gaps. It would also require an analysis of the potential outcomes of different strategies, and

weighing the advantages and disadvantages of each according to criteria which should include equity and sustainability.

It was suggested that fundamental reform in the context of political instability is feasible if the objectives are modest, and if implementation is phased over time. Two striking features of the health system in Uganda would threaten such an approach. Firstly, the nature of the pre-conflict health system exerted a powerful set of pressures on the direction of policy development which were extremely difficult to resist. Secondly, more fundamentally, the paucity of resources available at the national and household level represent the major constraint to health development. The assumption that reorientation to PHC will help to alleviate the pressure on national and external aid budgets suggests that PHC would be cheaper than the existing patterns of provision. This has not been supported by the experience of other countries (see for example, Segall, 1983).

While these two arguments, one political, one financial, suggest that the strategies adopted in Uganda were perhaps predictable, the research has suggested that they came at great cost. The experience of Uganda in responding to the health crisis inherited in 1986 offers great opportunities for donors and national governments to learn about the potentials and risks of different rehabilitation scenarios. Building upon the lessons will require using techniques of policy analysis to understand the response of policy elites to the rehabilitation task, and of identifying entry points through which some influence can be gained over the policy process.

The potential to establish rational criteria to guide the health policy process remains relatively untested, particularly under conditions of great uncertainty and dislocation of conventional policy arenas. What remains apparent, however, is that without clear, albeit modest, policy objectives, the effects of conflict on health systems and the response to them will continue to haunt policy-makers and donors long after relative peace has been secured.

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Annex 1: **Table of Key Issues in Post-conflict situations showing interaction of policy analysis model (Grindle & Thomas, 1991) and Health systems Analysis model (Roemer, 1991)**

	TECHNICAL ANALYSIS	BUREAUCRATIC MOTIVATION	POLITICAL SUPPORT	INTERNATIONAL LEVERAGE
HEALTH NEEDS	Availability and appropriateness of epidemiological & socio-economic data regarding health needs and population health status. Use of technical analysis in post-conflict policy design.		What priority was accorded to particular health problems.	What priority was accorded to particular health problems.
RESOURCES				
Human	Availability of data re: distribution & type of human resources; technical analysis of training needs; renumeration mechanisms.	Methods used for planning human resources, incremental or radical reform in post-conflict period; availability of appropriately trained & motivated human resources within planning & implementing agencies.	Political pressures for 1ery/ 2ery & 3ery training.	Impact of international agencies on human resources in public sector – absorption/ training strategies; role of intl. agencies in human resource development.
Physical	Availability of data re: distribution & type of physical infrastructure; assessment cost implications of alternative physical reconstruction plans.	Bureaucratic stakeholders in reconstruction, priorities and preferences for reconstruction sites and type of facility.	Political pressure for 1ery, 2ery, 3ery facilities; political factors influencing distribution of resources.	Preference of intl agencies for type of facility – 1ery, 2ery, 3ery. Methods of prioritizing reconstruction – geographical, other.
Supplies & Equipment	Availability of data regarding remaining equipment & supplies; methods used to prioritise replacement of equipment & supplies	Bureaucratic stakeholders in drug procurement and distribution.	Political pressure for 1ery, 2ery, 3ery facilities; political factors influencing distribution of resources.	Role of international agencies in the rehabilitation of supplies & equipment – prioritisation of these.

	TECHNICAL ANALYSIS	BUREAUCRATIC MOTIVATION	POLITICAL SUPPORT	INTERNATIONAL LEVERAGE
MANAGEMENT				
Policy	Role of technical analysis in policy process.	Relationship of executive and political branches of government: role of permanent civil servants in policy design; availability of bureaucratic cadres.	Place of health in national recovery plan; inter-sectoral policy implications of national political structures.	Role of international agencies, including NGOs, in policy formulation; impact of international aid conditionalities.
Planning	Methods of prioritizing data collection & analysis; coordination of data collection & analysis; technical planning capacity: budgeting capacity; availability of data for planning.	Availability of human resources for planning: renumeration & motivation for planners; inter-ministry co-operation.	Political priority accorded to national recovery plan.	Role of international technical advisors: aid resources allocated to rehabilitation of planning mechanisms: planning methods adopted to translate relief into development programmes.
Administration	Use of audit-style information on administrative capacity; training of administrators.	Availability of human resources; renumeration mechanisms: accountability structures.	Decentralization strategies?	Role in rehabilitation of public administration strategies: coordination mechanisms for international aid.
ECONOMIC SUPPORT				
Ministry of Health	Data re: availability of finance and its sources; technical analysis of recurrent cost implications of capital expenditures: conformity of plan to budget, conformity of budget to actual expended. Relative allocations to 1ery. 2ery, 3ery sectors. Availability of data on total health care expenditure.	Institutional capacity to relate budgeting to planning activities; particularly, inter-ministerial cooperation in budget preparation; technical capacity for long-term economic forecasting and financial analysis. Type of approach to health planning - incremental, comprehensive?	Political commitment to health reflected in actual allocations to health sector; impact of continued defense expenditure on social sector.	Share of international aid to health sector; share of intl aid through MOH.

	TECHNICAL ANALYSIS	BUREAUCRATIC MOTIVATION	POLITICAL SUPPORT	INTERNATIONAL LEVERAGE
Ministry of Local Government	Data re: availability of finance; & its sources technical analysis of recurrent cost implications of capital expenditures: conformity of plan to budget. Relative allocations to 1ery, 2ery, 3ery sectors.	Institutional capacity to relate budgeting to planning activities: particularly, inter-ministerial cooperation in budget preparation; technical capacity for long-term economic forecasting and financial analysis. Type of approach to health planning - incremental. comprehensive?	Relative share of government expenditure to MOLG; share of MOLG expenditure to health. Relationship MOH and MOLG, relative power of two.	Role of international aid in financing local government health budget; impact of int'l donors on decentralization of health planning financing.
IGOs/Multi-laterals	Availability of finance; analysis of long-term cost implications of IGO activity, particularly capital expenditure; relative share of budget to 1ery, 2ery, 3ery.	Incentives & problems in coordination of international agencies.	Political strategies to access international aid; political strategies to control int'l aid.	% IGO budget to health; share of IGO health expenditure as % of total health expenditure; impact of IGO activities of patterns of financing, eg insurance, community financing.
NGOs/missions	Availability of finance; analysis of long-term cost implications of IGO activity, particularly capital expenditure; relative share of budget to 1ery, 2ery, 3ery.	Incentives & problems in coordination of NGOs & missions.	Political attitude to NGOs; policy attention to NGOs.	% health expenditure by NGOs; NGO expend. on health as % of total; impact NGO activities on strategies of health sector financing.
Private - modern & traditional	Assessment of scale of private sector; inclusion of these estimates in planning activities.	Enforcement of legislation controlling private sector provision; bureaucratic stakeholders in private provision.	Ideological stance towards private sector; role of private sector outlined in policy statements.	Int'l policy stance to private sector; choice of private sector as implementing institutions.

Annex 2: Framework of questions, information sources & indicators

NB this list is indicates the type of question that were asked during the fieldwork. As the research progressed, questions were added and removed as issues became clearer overtime. This framework is not therefore intended to be exhaustive.

QUESTION	SOURCE	INDICATOR
HEALTH NEEDS		
What was the impact of conflict on health status?	Literature & document review; interviews with key MOH staff; health workers	Significant change in IMR, U5MR. Incidence of disability; impact on mental health.
What are the main health problems now?	Document review; interviews key MOH staff, health workers	10 primary causes mortality & morbidity
Are any groups - geographical, ethnic, social - particularly vulnerable?	Document review; interviews with key MOH staff, health workers?	Identification of "at risk groups", eg repatriated refugees; war widows etc.
RESOURCES		
Human Resources		
What was the impact of conflict on human resources: doctors, nurses. other?	Document review, interviews with MOH planning unit; training centres etc.	Comparisons doctor/nurse:patient ratios pre/post conflict: comparison distribution of doctors/nurses per/post conflict. Changes in training patterns - by cadre type.
Were any measures taken since the end of the war to audit human resources? If so, what type? Who financed and undertook these measures?	Document review (human resource surveys); interviews MOH planning unit; training centres; int'l agencies with training role.	Presence/absence human resource survey.
What policies were adopted to develop human resources at the end of the war? How were these policies developed? How were they financed?	Document review; interviews MOH, training centres; int'l agencies with training role.	Presence/absence of policy statement on human resources. Conformity of findings of survey with recommendations in national planning documents (ie utility of survey for plan) Allocation of resources to training different types of health worker - 1ery, 2ery, 3ery.

Annex 2: Framework of questions, information sources & indicators

QUESTION	SOURCE	INDICATOR
How successfully have these projects been implemented? What were the major constraints - technical, bureaucratic, resource limitations?	Document review; interviews with MOH, training centres, int'l agencies with training role; trainers. Focus group discussions with ministries, health workers & int'l agencies.	Comparison target and actual training performance; broad consensus in key factors affecting implementation.

Annex 2: Framework of questions, information sources & indicators

QUESTION	SOURCE	INDICATOR
PHYSICAL RESOURCES		
What was the impact of conflict on primary health care facilities?	Document review - including reconstruction plans; interviews with health staff in selected sites.	Comparison pre/post war availability of infrastructure.
What methods were used to audit the available physical resources for health? Who undertook these?	Document review; interviews with MOH: interviews with int'l agencies funding physical reconstruction in health sector.	Identification of methodologies used for audit. Identification of key financing agencies.
What priority was given to reconstruction of 1ery, 2ery, 3ery facilities? How were these priorities chosen?	Document reviews, including budgetary statements, interviews with MOH, interviews with int'l agencies funding physical reconstruction in the health sector	Relative share of 1ery, 2ery, 3ery in reconstruction budgets
To what extent were these priorities achieved in practice?	Document reviews, including budgetary statements.interviews with MOH, interviews with int'l agencies funding physical reconstruction in the health sector	Relative share of 1ery, 2ery, 3ery in actual expenditure figures
What methods were used to assess the recurrent cost implications of capital reconstruction costs?	Selected reconstruction plans for 1ery sector; interviews with MOH, funding agencies.	Presence/absence of recurrent cost analysis
SUPPLIES & EQUIPMENT		
What was the impact of conflict on the availability of supplies and equipment? How were any estimates made of these costs? By whom were these made?	Document reviews: interviews MOH, district health facilities	Presence/ absence of physical resource audit. Identification of information source. Estimate of financial costs of replacing lost equipment & supplies.
How were priorities for rebuilding supplies set? How were these coordinated between different agencies?	Document reviews: interviews MOH, district health facilities; interviews key int'l agencies responsible procurement drug & equipment.	Presence/absence plan to reestablish supplies; allocation of resources to 1ery,2ery,3ery services; mechanisms & enforcement of these to control imports of equipment & supplies
ECONOMIC SUPPORT		
What changes have there been in the % of GDP going to the health sector in the pre-, intra, and post-conflict periods?	Document review.	Changes in % GDP to health over time.

Annex 2: Framework of questions, information sources & indicators

QUESTION	SOURCE	INDICATOR
What have been the major changes in the sources of financing within the MOH in the pre, intra and post-conflict periods?	Document reviews; interviews MOH, Ministry of Finance	Relative share MOH income from taxation, aid, other over time.
How were reconstruction programmes costed? What was the impact of the reconstruction programme on the relative share of capital vs recurrent expenditure?	Review budgetary statements & actual expenditures (MOH. MOF, international agencies)	Relative share MOH budget spent capital/ recurrent over time.
What measures were taken to calculate the recurrent cost implications of capital reconstruction?	Review reconstruction project documents, interviews MOH, MOF, funding agencies.	Presence/absence of recurrent cost analysis; presence/absence of clear plan as to who will finance long-term recurrent costs.
Have there been any changes in central-district financing arrangements in the post-conflict period?	Document review; interviews MOH, MOLG	Financing, administrative decentralization
What has been the role of foreign aid in financing the capital costs of reconstruction? Which were the most important agencies? What were their priorities? How were these set?	Document review; interviews MOH, MOF, interviews key international agencies	Share of int'l aid in MOH capital budget; share of int'l aid overall health expenditure. Identification major financing and implementing agencies in health sector reconstruction
What were the main channels for reconstruction aid? Public or private? Central or local government sector? For-profit or non-profit?	Document review; interviews MOH, interviews key international agencies; focus group discussions.	Trends in implementing patterns - choice of institutions by international donors. % share of international aid to public: private, central: local institutions
What is the relative share of NGO expenditure on health? How has this changed in the pre-, intra- and post-conflict periods?	Document review; interviews MOH; interviews indigenous/ int'l NGOs. Focus group discussions.	Changes in NGO share of health expenditure. Ratio of int'l aid channelled thro' NGOs; share of govt expenditure channelled thro' NGOs.
Has the role of the private, for profit sector changed in health provision since the pre-conflict period? If so, in what ways? How have any changes been assessed	Document review: interviews MOH, interviews Ministry of Finance	Changes in share of health expenditure in private, for profit sector (traditional & modern)
MANAGEMENT		
POLICY		
Who were the key actors in policy formulation? What were the respective role of the executive and bureaucratic branches of government?	Interviews political party leaders; ministers of health: ministers of finance: civil servants MOH; NGOs & IGOs	Political/bureaucratic (not) perceived as actors key in policy design

Annex 2: Framework of questions, information sources & indicators

QUESTION	SOURCE	INDICATOR
What was the role of technical analysis in informing policy choice?	Document review; interviews policy-makers & planners; focus group discussions	Technical analysis perceived as important/ unimportant determinant of policy choice
What human resources were available for policy-making in the primary health care sector? civil servants? medically-trained politicians? international advisors?	Interviews MOH; focus group discussions	Changes in number/type of planning/policy unit members.
What was the role of international policy advisors - direct/indirect	Interviews MOH: interviews bilateral/ multilateral representatives	International advisors constituted important members of the policy team; international advisors perceived as influential in policy process by national govt. political & bureaucratic actors
How did international agencies plan for the translation of relief into longer term development initiatives?	Interviews MOH; interviews NGOs, bilateral & multilateral agencies	Presence/ absence strategies for translation of relief --> development
What priority was given to health in national budgets/national recovery plan?	Document review. Interviews with political organizations.	priority to health sector in major policy documents; level of financial support accorded to health sector
What was the role of any grassroots political and other organizations in the health recovery plan?	Document review; interviews representatives grassroots political organisations: interviews MOH	Absence/presence strategy for involvement of grassroots organizations in national recovery plans. Perceptions of these organizations of their role in practice.
PLANNING		
How was health planning capacity affected by conflict? Data collection capacity: human resources for planning: monitoring & evaluation programmes?	Documents; interviews MOH; interviews international agencies, including NGOs; focus group discussions	Comparison pre-/ intra-, post-conflict activities of planning unit - presence/ absence surveys, disease surveillance studies etc. Comparison human resources available for planning in study period
Were any measures taken to increase planning capacity in the post-conflict period? Who was responsible for the design of any initiatives? Who financed any initiatives?	Document reviews; interviews MOH; interviews international agencies	absence/presence plan for strengthening planning capacity Sources of financing for any plans
Administration		

Annex 2: Framework of questions, information sources & indicators

QUESTION	SOURCE	INDICATOR
How was implementational capacity affected by conflict? management, communications, supervision, monitoring & evaluation, budgetary control. What were the main constraints to implementation - insecurity, resources, other?	Interviews MOH, interviews district level health teams; interviews NGOs	Perceptions of main factors constraining implementation.
To what extent is implementation still constrained by these factors?	Interviews MOH, interviews district level health teams; interviews NGOs	Perceptions of main factors constraining implementation. Comparison of these with those listed in preceding question
Were any structures developed during conflict to facilitate local-central cooperation? How have these changed in the post-conflict period?	Interviews MOH/MOLG	Presence/absence decentralization strategy in study period.
Were any structures developed to guide inter-sectoral collaboration in post-conflict reconstruction? If so, what were these? How successful were they?	Interviews MOH, interviews international agencies.	Presence/absence strategy for inter-sectoral collaboration
Were any particular problems experienced in re-establishing local level administrative structures? If so, what were these? Have any measures been taken to resolve them? If so what, and by whom?	Interviews MOH, MOLG; district health teams; international agencies	Management, technical, resource problems identified at local level by district teams and/or central level. Presence/ absence of strategy for their resolution.
What approaches were adopted to delivery primary health care services in the post-conflict period? Horizontal/ vertical? Did these differ from the strategies adopted in the pre-conflict era? If so, how? What factors the influenced choice of strategy?	Document reviews; interviews MOH, health workers, international agencies	Principal primary health care strategy identified as horizontal/vertical.
Have NGOs played any role in influencing policy development in the post-conflict period? If so, how? Give examples of policies which NGOs have influenced. What role have they played in implementing government policy?	Document reviews; interviews MOH, interviews district health teams; interviews NGOs.	NGOs perceived as (un)influential in health policy development and implementation. Identication of policies influcenced/ implemented by NGOs.

Abbreviations:

IGO International Governmental Organisation - multilateral
MOF Ministry of Finance
MOH Ministry of Health
MOLG Ministry of Local Government
NGOs Non-governmental Organizations

Dr Tom Barton	Technical Advisor, Child Health Development Centre
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Dr Jan Borg	Technical Advisor, Save the Children Fund/ Ministry of Local Government
Steve Cavell	Country Director, Save the Children Fund
B.Fredrickson	Counsellor, Royal Danish Embassy
Michael Frost	First Aid Secretary, Overseas Development Administration
Dr Darfoor	Technical Advisor, WHO
Colin Glennie	Head of Health Section, UNICEF
J. Harmsworth	Prime Minister's Office
Mr Kalete	Aid Coordination Office
Dr Imani	Head, Rural and Urban Health Division, Ministry of Local Government
Stella Kabaganda	Medical Foundation for the Victims of Torture
Patrick Kadama	Head, Planning Unit, Ministry of Health
Dr Kanwesige	Acting Director Medical Services, Ministry of Health
Dr Lungu	Acting Director, World Bank First Health Project
Dr Madra	Director, AIDS Control Programme
Dr Malenkhwa	Director, Community Based Health Care Association
Mr Mulengenzi	Principal Engineer, Hospital Rehabilitation Division, Ministry of Health
Mrs Mugwera	Head, Social Services Division, Ministry of Finance & Economic Planning
Mr Obidegwu	Resident Economist, World Bank
Mr Oloya	Coordinator, Northern Uganda Reconstruction Programme
Professor Owor	Department of Pathology, Makerere University
Dr I Rizzo	Head, Primary Health Care section, UNICEF
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T. Sseezi–Cheeye	Editor, Uganda Confidential
Nick Stockton	Country Representative, Oxfam
Lars Sylvan	Deputy Resident Representative, UNDP
Haruna Kyamanywa	Assistant Resident Representative, UNDP
Veronica Walford	Senior Economist, Ministry of Health

Meetings in Soroti

Mr Olatum Ocum	District Executive Secretary
Ms Grace Okello	Teso Commission
Mr Ongula	RCV Secretary General
Mr Okluma	RCV Chairman
Mr Ongole	NURP coordinator, Soroti district
Mr Etoori	Chairman, District Health Committee
Dr Acong	Acting Medical Superintendent, Soroti Hospital
Dr Opio	Doctor, Soroti Hospital
Mr Okok P O'Ceng	District Administrator
Olkell N Elepu	Deputy District Administrator
Dr Nicholas Okwana	District Medical Officer
Ms E Wange–Acheng	District Health Visitor
Mr Esudu Eswilu	Sub–county chief, Serere
Amuria	RC4 Secretary for Women, women's group, women passers–by; Medical Assistant & Nursing Aid Amuria health centre; group of men – RC1 Chairman
Kaberdimido	Health Workers, RCV vice–Chairman, Sub–County Chief
Luala Mission Hospital	Nursing Staff
MSF Workshop	Health workers from Soroti district
Oditel Mission	Health workers, religious & secular leaders

Serere Health Centre	Health workers
Serere	Health Managment Committee
Serere	Women's group

Luwero Meetings

Hon Kisamba-Mugerwa	Minister of State for the Rehabiliation & Reconstruction of Luwero
Mr Waswa	Traditional healer
Mr Sam Kasule	Head, Bututumula Orphans Project, AMREF
Mr Kayonda	RC3 Chairman, Semuto sub-county
Mr P Senkubege	Traditional Birth Attendant
Mr Ezekeri Serugoti	Chairman RC1 Semuto
Regina	Head of CBHC Project, AMREF, Semuto
	District Medical Officer
	District Health Inspector
	District Health Visitor
	District Executive Secretary

Bututumula Health Centre	Health Workers
Kikubampanga	Women's group
Kitoto	RC1 Officials and village women & men
Kyoga	RC1 officials and village women & men
Nyanga	RC1 officials, CBHC workers, village members
Semuto Health Centre	Health Workers
Yadwe Village	RC1 officials and village women & men

Annex 4: Documentation Sources

Document Sources – London

Institute of Commonwealth Studies library
London School of Economics Library
London School of Hygiene & Tropical Medicine library
Save the Children Fund – Overseas Research & Information
School of Oriental & African Studies library

Main Document Sources – Uganda

AMREF
Child Health Development Centre (including Dr Barton personal collection
Ministry of Finance & Economic Planning (Library)
Save the Children Fund (Uganda)
UNICEF (Uganda)